Case No. _____

IN THE SUPREME COURT OF NEVADA

UNITE HERE HEALTH, a multi-employer health and welfare trust, as defined in ERISA Section 3(37); and NEVADA HEALTH SOLUTIONS, LLC, a Nevada limited liability company,

Petitioners,

vs.

EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK, THE HONORABLE TARA CLARK NEWBERRY, DISTRICT COURT JUDGE,

Respondent,

- and -

STATE OF NEVADA EX REL. COMMISSIONER OF INSURANCE, BARBARA D. RICHARDSON, IN HER OFFICIAL CAPACITY AS STATUTORY RECEIVER FOR DELINQUENT DOMESTIC INSURER, NEVADA HEALTH CO-OP; and GREENBERG TRAURIG, LLP,

Real Parties in Interest.

District Court Case No. A-15-725244-C, Department XXI

APPENDIX TO PETITION FOR EXTRAORDINARY WRIT RELIEF
VOLUME 12 OF 19

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February 25, 2021

APPENDIX TO PETITION FOR EXTRAORDINARY WRIT RELIEF
VOLUME 12 OF 19

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TAB 33

TAB 33

EXHIBIT 4

EXHIBIT 4

MINUTES OF THE REGULAR MEETING OF
THE FORMATION BOARD OF DIRECTORS OF NEVADA HEALTH CO-OP

February 19, 2014

A regular meeting of the Board of Directors of Nevada Health CO-OP, a Nevada non-profit, non-stock cooperative corporation (the "CO-OP"), was held on February 19, 2014, at 3900 Meadows Lane, Suite 100, Las Vegas, NV 89107 pursuant to notice duly given. The following Directors were present: Jeff Ellis, Bobbette Bond, Christine Carafelli, Kathy Silver, Tom Zumtobel and Danny Thompson. D Taylor was not present.
The following guests were present: Lynn Fulstone Esq. (Lionel Sawyer Collins) Basil Dibsie, Chief Financial Officer (NHC), Dr. Nicole Flora, Chief Medical Officer, (NHC) and Pam Egan, Chief Development Officer (NHC). Cara Elias Esq. (Brownstein Hyatt Farber Schreck) and James Clough Esq. (Seyfarth Shaw, LLP) attended telephonically. Michele Schultz was present as minute's taker.

Mr. Ellis called the meeting to order at 1:10pm.

I **Executive Session:** *Language for this section will be drafted and circulated under separate cover*.

II **Approval of Minutes:** Mr. Ellis asked members if there were any objections or corrections to the January 22, 2014 Board meeting minutes. No objections were heard. Ms. Silver motioned to approve the minutes. Mr. Thompson seconded Ms. Silver's motion. All in favor. Motion carried.

Mr. Zumtobel asked Mr. Ellis to adjust the order of the Board Agenda so that he could present an update on The Silver State Health Insurance Exchange while Mr. Brignone was still present. Mr. Ellis asked Board Members if there was any objection to the request. No objection heard.

V **Operational Report:**

1. Nevada Health Link Update: Mr. Zumtobel explained the on-going issues and challenges the CO-OP has been experiencing with the enrollment process through the State Exchange. Mr. Zumtobel explained that he has been participating in three meetings a week with the Governor's

office, the other carriers and Xerox to communicate the challenges the CO-OP is experiencing with data submission from Xerox to the CO-OP. Currently, there are more than 3,000 members that are on Xerox's pending list that the CO-OP has not received any data on to date. The 834's and 820's remain being delayed getting to the CO-OP and when received, the data is incomplete. Mr. Zumtobel informed the Board that he is speaking regularly with Governor Sandoval's office regarding the CO-OP's challenges with Xerox. He went on the say the contract the State of Nevada has with Xerox has some concerning gaps. One such gap being no performance guarantee written in the contract between the State and Xerox. Mr. Zumtobel reported to the Board that at the last Exchange Board meeting during public comments, a consumer came forward and reported that he had suffered a heart attack December 31, 2013 resulting in his need for immediate heart surgery that left him with a 410k hospital bill. The consumer was reported by Xerox to be a Nevada Health CO-OP member although the CO-OP had no record of this. Xerox had not communicated eligibility to the CO-OP on this consumer's behalf. Mr. Zumtobel went on to say from what has been communicated thus far, this consumer originally looked at the CO-OP but ultimately selected another carrier (Health Plan of Nevada). Mr. Zumtobel stated to the Board that Xerox is negatively impacting the CO-OP's membership. If the CO-OP was aware of this consumer being our member the CO-OP could manage his care. Mr. Ellis voiced his concern as to where the State's responsibility to the consumer and to the CO-OP lied. Mr. Ellis went on to say that the CO-OP had no opportunity to manage the patient. Mr. Zumtobel introduced to the Board the idea of sending a letter to Governor Brian Sandoval outlining the CO-OP's complaint that the CO-OP had no opportunity to manage this patient, the negative impact Xerox is having on the CO-OP's membership and the difficulty of advocating through this broken exchange. The Board Members and CO-OP attorneys spent time strategizing. Mr. Brignone discussed his thoughts to the Board. Board members all agreed to have the CO-OPs' attorneys prepare a letter to Xerox and to Governor Brian Sandoval outlining: 1) the problems the CO-OP is experiencing with Xerox 2) How Xerox has injured the CO-OP's members by not addressing the over 3, 000 members on the pending list 3) How Xerox has and continues to hurt the CO-OP's credibility in the market place.

III **Financial Report: December Financial Statements:** Mr. Dibsie presented to the Board the December 2013 Balance Sheet, Statement of Operations and Cash Flow Statement. The Board members discussed various aspects of these financials reports. Mr. Dibsie informed the Board that the CO-OP had a total of forty-five (45) employees at the end of 2013. In January 2014, there was one (1) additional employee hired. Mr. Dibsie informed the Board he had extended two

(2) employment offers for his department to fill the positions of Accounts Payable Clerk and Underwriter for Large Groups. These two (2) additions to staff will bring the staff total to forty-eight (48) CO-OP employees by the end of March 2014.

CMS Additional Funding Request Update: Mr. Dibsie updated the Board on the status of the CO-OP's request for additional funding from CMS. He explained that two weeks prior he participated in a status call with CMS whereby CMS was seeking CO-OP responses to additional questions around its request for funding. Mr. Dibsie stated the questions CMS were seeking answers to were: 1) CMS wanted the CO-OP's Administrative Budget for 2014. 2) CMS requested the CO-OP's membership forecast for 2015-2033. Mr. Dibsie informed the Board that it appears the process by which CMS has used in the past to determine the outcome of CO-OP's seeking additional funding as changed. Mr. Dibsie added that the CO-OP and CMS are still engaging in conversations around the CO-OP's request and looks forward to the final disposition. Mr. Ellis asked how the remaining solvency funding would be transferred to the CO-OP. Both Mr. Zumtobel and Mr. Dibsie were unsure how the remaining solvency funding would be delivered to the CO-OP, or the exact request process. Mr. Zumtobel stated he felt CMS was trying to work through delivery method particularly with the current political climate in Washington DC. Mr. Ellis asked if the CO-OP had started to pay claims. Ms. Egan reported to Mr. Ellis and the board that there has been a total of 2, 800 claims received, approximately 2,300 of which were submitted in paper form and of that, 42 claims have been paid. Total amount of claims paid out to date is $8k.

2014 Forecast/Draft Budget: Mr. Dibsie presented to the Board spreadsheets related to Nevada Health CO-OP's 2014 Forecast which illustrated the overall assumptions for Membership, Premium Revenue, Benefit Cost, Investment Income, and Operational Administrative Expenses. Additionally, Mr. Dibsie reviewed Nevada Health CO-OP's 2014 Budget-Forecast which outlined the monthly forecast summary with membership at the top and the financials at the bottom. Lastly, the Preliminary Operational Budget was presented to the Board. Mr. Dibsie explained the detailed listing of the CO-OP's Operational Administrative Budget. He explained that the first three columns in the spreadsheet illustrate the operational figures for 2013 while the fourth column represents the Preliminary Budget for 2014. Ms. Carafelli expressed her satisfaction with Mr. Dibsie's presentation.

IV Outreach Plan

This section was not discussed.

Due to the meeting going over the allotted time, Mr. Ellis motioned to adjourn the meeting. Mr. Zumtobel asked that the Board take up the issue of him transitioning from Unite Here Health to Nevada Health CO-OP at the March meeting. Mr. Zumtobel stated he always planned to come over to the CO-OP and would like direction on next steps. Ms. Bond suggested that the Board consider forming a separate committee to focus on the negotiations of Mr. Zumtobel's transition. Secondly, Ms. Bond asked the Board to take up the issue of the CO-OP adopting a policy of not hiring relatives at the March 2014 Board meeting. Mr. Ellis accepted Ms. Bond's request to have these points heard at the next Board meeting.

Mr. Ellis adjourned the meeting at 2:40pm (PST).

EXHIBIT 5

EXHIBIT 5

MINUTES OF THE REGULAR MEETING OF
THE FORMATION BOARD OF DIRECTORS OF NEVADA HEALTH CO-OP

May 23, 2014

A regular meeting of the Board of Directors of Nevada Health CO-OP, a Nevada non-profit, non-stock cooperative corporation (the "CO-OP"), was held on May 23, 2014, at 3900 Meadows Lane, Suite 100, Las Vegas, NV 89107 pursuant to notice duly given. The following Directors were present: Jeff Ellis, Christine Carafelli, Tom Zumtobel and Danny Thompson. Bobbette Bond and Kathy Silver attended telephonically. D. Taylor was not in attendance.
The following guests were present: Basil Dibsie, Chief Financial Officer (NHC), Dr. Nicole Flora, Chief Medical Officer, (NHC) and Gwendolyn Harris, Compliance Officer (NHC). Cara Elias Esq. (Brownstein Hyatt Farber Schreck) attended telephonically. Michele Schultz was present as minute's taker.

Mr. Ellis called the meeting to order at 1:15pm.

I **Approval of Minutes:** Mr. Ellis asked Board members if they had the opportunity to review the minutes from the May 2014 Board meeting. Mr. Ellis asked if there were any objections to the May 2014 Board meeting. No objections were expressed. Mr. Thompson motioned to approve the minutes. Ms. Carafelli seconded the motion. All in favor. Motion carried.

II **Financial Report:**

Enrollment: Mr. Dibsie presented the enrollment figures as of June 16, 2014. There are 16,200 members enrolled with the CO-OP. In the past month, the CO-OP gained 1,100 new members. Mr. Ellis asked how the 2,000 off-exchange members were added. Ms. Egan reported those members are non-subsidy eligible individuals and members of small groups who were enrolled through InsureMonkey. Mr. Ellis asked how these individuals and small groups were billed. Ms. Egan explained the CO-OP generates the monthly billing directly to the individual and small groups and processes the payment from the members via check or credit card. Mr. Ellis asked if the CO-OP has regained the market share on the Exchange. Mr. Dibsie stated in the last report issued by the Exchanged a few weeks prior, the CO-OP was trailing United Health Care by .10%, a difference of approximately 130 people. Mr. Zumtobel reported that Xerox gave the CO-OP a total of 909 terminations in the past few weeks that dated back to January. Board Members

discussed the financial impact on the CO-OP as a result of the late termination notification from Xerox. Mr. Zumtobel stated if the member paid its premium and is subsidy eligible, the CO-OP is obligated to pay the providers. The CO-OP will be reviewing the termination list to decide if a course of action is warranted for the financial recovery of claims paid on behalf of terminated members as a result of the late notification of the termination list provided by Xerox.

April Financial Statements: Mr. Dibsie reviewed the Statement of Operations report for April 2014. Mr. Dibsie stated the CO-OP's membership is currently 3,334 short of projected members but enrollment should catch up to projections by the end of July. The premium revenue PMPM is higher than projected by 17% due to demographics. Mr. Dibsie pointed out the benefit cost for the month is higher at $32.69 PMPM which is 14% higher than projected.

Mr. Dibsie reviewed the categories over budget for the month on the Statement of Operations report. Broker Commission category: Mr. Dibsie explained that the CO-OP has generated more Broker business than expected which has resulted in larger commissions paid out. Mr. Ellis asked how brokers are accessing the State Exchange. Mr. Zumtobel explained the Brokers log in on behalf of the member and populate the application or the Brokers can use their Broker numbers to enroll members. Ms. Carafelli asked if participants pay a broker fee. Mr. Zumtobel responded that only the carrier pays Broker commission. Mr. Dibsie reported the Brokers have enrolled 2,500 members on behalf of the CO-OP and expects the Brokers to be helpful with small and large group business in the coming year.

The Actuarial expenses for the month are over budget. Mr. Dibsie explained that due to the filing deadline being moved up, the Actuarial services were needed earlier than originally budgeted.

The Customer Service/Enrollment fees for the month are over budget due to a fee reconciliation for InsureMonkey. Cost were reconciled for actuals incurred from January – April 2014. Approximately $32,000 was for months prior to April.

The enrollment system will have an ongoing depreciation value each month of $23,000. This amount was not in the original budget and will re-occur each month. This is a non-cash item.

The CO-OP ended the month with general & administrative costs at $104,243 unfavorable to budget.

Mr. Dibsie reviewed the Supplemental Schedule – Premium & Membership report for April 2014. The spreadsheet breaks the premium revenue into subsidy and unsubsidized revenue on and off Exchange. Exchange subsidy is approximately 71% of premium revenue generated versus none subsidized. Currently, there are 1,400 members on Exchange not receiving a subsidy.

Mr. Dibsie reviewed the Balance sheet for April 2014. He pointed out the CO-OP's operating account is at $1.3M and the premium account is at $4M. Mr. Ellis asked if bills were being drawn out of the premium account. Mr. Dibsie responded that from the premium account, claims and capitation were being paid. Additionally, 15% of premium revenue is being transferred to the operating account where Administrative costs are being paid. Mr. Ellis questioned the ability of the operating account to pay Administrative costs even with the 15% transferred from the premium account. Mr. Zumtobel explained that the CO-OP is in the process of preparing to go to the Division of Insurance to request a draw down from the Solvency monies for operating expenses. Mr. Ellis asked if the CO-OP was above its Capital Surplus requirement. Mr. Zumtobel responded CMS requires premium dollars above 500% and the Division of Insurance requires 200% above risk based capital. CO-OP still has $8M solvency from CMS that has not been funded yet.

Mr. Dibsie reported that the CO-OP's end of the month assets are at $29M.

Mr. Dibsie presented a 4 month Statement of Operations. Mr. Ellis asked about the decrease expense in outreach and advertising. Mr. Zumtobel responded that the media expense has been stopped during the summer and anticipates an increase in this category prior to open enrollment.

Claims Reports: Mr. Ellis asked how the claims system was functioning. Ms. Egan reported that there have been challenges with the functionality of the system however, claims are being processed. The current backlog is at 12,000. Ms. Carafelli asked how far the claims dated back. Ms. Egan reported some of the most aged go back to January. The CO-OP is trending in a good direction as 69% of backlogged claims received through June 17th are currently in processed status. The CO-OP has developed a claims dashboard to monitor the daily total number of claims received, paid claims, total in the system unpaid by number of claims paid on date received, number of claims paid within 5 days of receipt, and percent of claims paid within 10 days or receipt. The CO-OP is working to move claims out of the system. Such as, working through

glitches with the functionality of the Javelina system that has held back auto adjudication of claims. Ms. Egan went on to report The CO-OP is being strategic in moving the claims inventory out and not allowing any further backlog.

Mr. Dibsie presented the claims report as of June 2014. There are currently 10,000 pended claims in the system.

III Outreach Plan

Premium Billing Update: Mr. Zumtobel reported. Nevada will transition to a State Supported Exchange which is part of the Federal Exchange, healthcare.gov. Mr. Zumtobel stated he has heard good things about the shopping experience on the Federal Exchange whereby consumers find the process easier than the State Exchange with less screens to navigate through before being separated out into subsidy, non-subsidy and Medicare eligible. With the Federal Exchange taking over, carriers will be responsible for their own premium collection for on-Exchange members. In the past, the CO-OP has only collected for off-Exchange members. Currently, the CO-OP is not set up to handle this new protocol and thus is seeking an outside vendors to assist. The CO-OP has identified a company, Softheon out of Stoney Brook, Long Island. Softheon has experience in managing premium billing and can be helpful with interfacing with the State on the 834 eligibility files for members. The Federal Exchange allows consumers to go directly to the carrier to enroll or enroll through the Federal Exchange, healthcare.gov. This is a new process for the CO-OP. The CO-OP's current enrollment vendor, InsureMonkey, is close to finalizing the technology needed to enroll on Exchange and collect on Exchange payments. CO-OP leadership has not made a final decision as to which vendor to use. InsureMonkey believes they can have their technology up and running in time for the State Supported Exchange roll-out. It is important that the CO-OP is able to do direct enrollment so that participates have a shopping experience in order to be able to compete with the other carriers that do direct marketing to their websites. Another advantage of setting up direct enrollment is to prevent the unnecessary filing of 50 or so other plans for members that would not select these types of plans as they are subsidy eligible and would not want to lose their QHP. Ms. Bond and Mr. Zumtobel are working with the State of Nevada to request Grant monies to help pay for the new system for collecting premium.

Brady Linen: Mr. Zumtobel reported the CO-OP has been working with the Culinary Union and Brady Linen to develop a benefits plan for their workforce. The competitors to Brady are nonunion and pay their workers less. Brady requested the CO-OP's assistance in providing a

solution to their employee benefit needs. The CO-OP has proposed a large group "skinny" plan with 10 primary care doctors similar to a HMO plan. This option will benefit 1,000 employees and 2,000 dependents of Brady employees. Additionally, Brady will be contributing to the setting up of an on-site wellness station for their employees. A health advocate will be on-site at Brady to help educate and assist the workers and their families. Mr. Zumtobel stated the talks with Brady have been good and is hopeful the company will accept the proposed plan which would go in to effect January 2015. Ms. Bond highlighted the opportunity the Brady proposal provides the CO-OP to develop employer based healthcare advocacy and outreach in an effort to drive the cost of healthcare down for small groups.

Multi-State Plan: Ms. Bond reported she is working with NASHCO to complete the application for a Multi-State Plan. The Multi-State Plan creates a non-profit multi state product in 22-25 states that currently have CO-OP's. It is a great opportunity for NHC to get in the market for next year and work with various organizations. The multi-state plan offering will allow coverage for members that travel out of state. In 2015, the coverage in this market is at 2% in Nevada. In 2015 the limited product offering will be listed on the Exchange as "MSP" through NASHCO. Ms. Bond expects this plan to have better results in 2016 as NASHCO and the other CO-OP's work collaboratively together to develop the plan offering.

IV Operational Report:

Board Development:

Board Governance: Ms. Bond reported that the CO-OP has to have an Operational Board in place by the beginning of 2016. Ms. Bond and Ms. Harris are developing a transitional plan to outline the items and issues that need to be addressed to develop and formulate potential Board members. According to the By-laws, one member from the CO-OP's Consumer Advisory Group will be placed on Nominating Committee. The composition of the Board must include a higher number of CO-OP members than non-members by 2016. Ms. Elias discussed the timelines and By-laws related to the formation of the Operating Board and their duties. Ms. Bond proposed the date of the annual meeting at which the election of Board members will be voted on to be December 16, 2014. Mr. Ellis motioned to approve the annual meeting to take place December 16, 2014. All in favor. Motion carried.

2015 Pricing Discussion: Mr. Dibsie reported. The CO-OP is preparing to file its 2015 Plans with the Division of Insurance. The CO-OP has not eliminated any of the plan offerings from

2014. Additional plans have been added to the 2015 submissions. All carriers will face an administrative cost increase in 2015. The increase is due to the State Exchange fee increasing by $8 PMPM in 2015. Additionally, the reinsurance fee and transitional rate pool fees will increase in 2015. The CO-OP has to file its plans with the Division of Insurance by June 27, 2014. Mr. Ellis asked about the CO-OP's rates in Northern Nevada. Mr. Zumtobel stated the CO-OP has until mid-August to pull any plans with the Division of Insurance however, the rates cannot change. He went on to explain the CO-OP will not stay in Northern Nevada if the CO-OP's rates are not competitive. The CO-OP is waiting to receive from Milliman competitive rate estimates for doctors and hospitals in Northern NV. The CO-OP will then verify with Northern providers and hospitals that the CO-OP's rates are competitive and will be beneficial in the Northern region. Ms. Bond asked when the carrier rates go public. Mr. Zumtobel responded, mid-October. Mr. Dibsie reported the CO-OP's small group shop rates are decreasing as they are not part of the federal reinsurance pool. Mr. Ellis asked if the CO-OP had received reinsurance monies. Mr. Zumtobel responded the CO-OP will not receive reinsurance for 15 months.

CEO Contract: This topic was not discussed

Mr. Ellis adjourned the meeting at 2:30pm (PST).

EXHIBIT 6

EXHIBIT 6

nhc nevada health co-op

simply better

February 24, 2014

VIA EMAIL AND EXPRESS MAIL

Governor Brian Sandoval
101 North Carson St
Carson City, NV 89701
Email: governor@govmail.state.nv.us

Xerox State Healthcare, LLC
Attention: Will Saunders, President
8260 Willow Oaks Corporate Drive, Suite 600
Fairfax, Virginia 22031
Email: will.saunders@xerox.com

Dear Governor Sandoval and Mr. Saunders,

On behalf of Nevadans in search of effective health care, we write to express our grave and growing concerns with the failures of Xerox regarding the Silver State Health Insurance Exchange/ Nevada Health Link. These failures have caused real and damaging impact not only on Nevada residents needing Exchange coverage but also on Nevada's only nonprofit provider on the Exchange. Nevada residents and the Nevada Health CO-OP deserve and require that Xerox perform its contractual obligations.

As the only community-sponsored Consumer Oriented and Operated Plan in Nevada, and one of only 23 CO-OPs nationwide, the new Nevada Health CO-OP is a unique nonprofit insurance carrier of great value to Nevada and its citizens. It is run by Nevadans for Nevadans. Data show we have attracted 37% of the Exchange market share. The reason for our success, we believe, is that we designed a member-focused health care experience of active outreach and advocacy for patient needs. Our entire focus is on Nevada health care consumer advocacy through early engagement in our plans. However, Xerox's broken enrollment system has interrupted and delayed this patient focus, and been an absolute failure for patients in need. In fact, Xerox is undeniably the greatest threat to our operations for the many people that have not been able to enroll in the CO-OP, or have been enrolled incorrectly or incompletely.

The failures of Xerox, and the inability of the Exchange to reverse this failure, have caused serious problems for the CO-OP and for our patients as well. Most importantly, Xerox's failure has harmed those patients with immediate health care needs, who have been trapped and unable to access care effectively because of the nonworking Exchange processes. Lawrence Basich, the

man who presented testimony to the Board of the Exchange on February 13, 2014, is the best known example to date.

Mr. Basich testified that he both timely enrolled and paid for Exchange coverage. He later suffered a heart attack. He believed that his medical treatment on and after January 1, 2014 would be paid by his Exchange coverage. Long after his medical care, the CO-OP learned for the first time that Xerox believed Mr. Basich had enrolled in a CO-OP plan – this information came from Xerox after Mr. Basich's February 13, 2014 testimony. A week after the testimony, Xerox sent information to the CO-OP to enroll Mr. Basich. Since then, the CO-OP learned directly from Mr. Basich that he believes he had enrolled with another carrier, and that Xerox told him it would be "easier" to enroll in the CO-OP. It is still unclear today which carrier should have received enrollment information from Xerox with respect to Mr. Basich when he enrolled and paid for Exchange coverage, and who at Xerox decided what would be easier, and for whom.

Xerox is responsible for the situation reported by Mr. Basich. Xerox should bear the financial costs of Mr. Basich's experience: the premiums that he paid for coverage he could not access, the medical expenses he incurred without any guidance or support from his insurer's medical advocacy team, and any related costs that Mr. Basich has incurred since attempting to sign up for health coverage through the Exchange. In addition, Xerox should take immediate action to mitigate any reputational damage to the CO-OP caused by Xerox's failures and its attempt to deflect liability for Mr. Basich's medical claims from Xerox onto the CO-OP.

While patient advocacy is its mission, the CO-OP cannot advocate for members it knows nothing about, nor should it be forced to expend its resources trying to understand long lists from Xerox of incomplete, unidentified, and unresolved enrollments in order to determine who may be a CO-OP member. Mr. Basich's insurer, whether the CO-OP or another insurer, did not know about his enrollment until long after the fact and after it was too late to guide and help him. To ensure you understand the scope and gravity of the ongoing harm to Nevadans and damage to the CO-OP, our experience with Mr. Basich, outlined below, well illustrates the problems.

1. Xerox first indicated that Mr. Basich was a CO-OP enrollee on February 20, 2014, almost six weeks after his serious medical episode and seven days after Mr. Basich pleaded for help at the Exchange Board meeting. We later spoke with Mr. Basich regarding his enrollment and learned he believes he never selected the CO-OP as his carrier for Exchange coverage. He stated to us that Xerox indicated that it would be "easier" to communicate coverage with the CO-OP from January 1, 2014 until March 1, 2014 and then move him to the competitor plan.
2. There are many other Nevadans in the same position as Mr. Basich. For several months, the CO-OP has asked for information about the thousands of people

appearing on an Exchange list called a "pend" list that the state decided to create. We still are not clear about what constitutes inclusion in the pend list, though we have asked many times.

3. After several requests for information on the pend list of applicants, the only information Xerox provided to the CO-OP came on January 23, 2014, which contained partial information and no contact information on several thousand individuals, some marked eligible, some not. On that list, Mr. Basich appears, based on the Xerox coding, to be ineligible. His entries read "**IsEnrolled=FALSE, HasPaid=FALSE**." Yet, Xerox now says Mr. Basich was eligible for CO-OP coverage.

   Even this list was only provided to the CO-OP because we specifically asked for it in January, hoping to provide immediate support to the many Nevadans included on this list who were not receiving coverage. However, the list turned out to be unworkable because Xerox could not identify why people were on it, or provide enough information for us to investigate it. A second list, provided by Xerox on January 30, 2014, included over 2,300 individuals identified as "pending." Mr. Basich appears on this list, too, as "**IsEnrolled=FALSE, HasPaid=FALSE**." CO-OP.

   If the CO-OP or another insurer had been properly notified regarding Mr. Basich's enrollment, it would have been possible to establish a relationship as his advocate and navigator for his health care needs. Moreover, it would have been possible to ensure he received care at a network facility and medical management advocacy for the open heart bypass surgery he received on January 3, 2014. These measures would have reduced not only the medical claims costs to the insurer but also minimized the potential balance billing charges that Mr. Basich may be required pay out-of-pocket for his care. Instead, Mr. Basich and the CO-OP are being asked to blindly bear these unmanaged medical expenses. We believe the same is true for an unknown number of other individuals on the pend list who are eligible for coverage and needed medical care since January 1, 2014.

4. To this day, the pend list remains an obstacle rather than an aid. As of February 17, 2014, thousands of people remain on this pend list in the weekly reports provided by the Exchange - more than 8,000 individuals are reported as pending across all medical carriers, and more than 3,000 of these are identified as somehow belonging to the CO-OP. These individuals have not been contacted by any carrier. Their experience has been to remain utterly unserved by any insurance. They are left to assume that the insurance carrier has dropped the ball, when in fact the carrier has no way of engaging.

nhc nevada health co-op

simply better

The existence of thousands of "pending" applicants and Xerox's ongoing failure to timely communicate complete and accurate enrollment information causes reputational harm and unknown medical claims exposure for the CO-OP. The lack of support provided to Mr. Basich through his health care crisis is a result of Xerox's negligence. Xerox's attempt to hold the CO-OP liable for Mr. Basich's medical claims despite Mr. Basich's timely and proper enrollment with a competing carrier is an act of willful harm by Xerox against the CO-OP.

Xerox is liable to this individual, to other Exchange enrollees and shoppers, to the CO-OP, to our providers who cared for patients with no proof of eligibility, to the Exchange, and to the Nevada community at-large for its failures to timely and accurately communicate enrollment information. The enrollment status of the individuals on the Xerox pend list must be resolved as soon as possible in order to avoid future cases like Mr. Basich's and eliminate this source of immeasurable liability and damage to the CO-OP and other carriers on the Exchange. These completely unacceptable consumer experiences extend to the current enrollment process. Enrollees continue to experience technical quirks that shut down the website, slow process times, and unnecessarily complex enrollment steps.

These unresolved problems over five months, and the publicity regarding them, has greatly reduced the number of Nevadans who will even attempt to gain insurance this year on the Exchange. There is no way to recover from the impact of this poor execution, and the lengthy enrollment period will end without the enrollment of thousands of Nevadans who deserve much better than what they are getting from Xerox on the Exchange.

We must have a clear path forward immediately to ensure that all of these issues are resolved and that Nevadans have access to a full range of health care options.

We hope you receive our concerns with the same genuineness, sincerity, and commitment to Nevada citizens as we have made them in this letter. We look forward to receiving your prompt response and efficaciously resolving these serious issues to the benefit of all involved, especially our fellow Nevadans. Thank you.

Very Truly Yours,

Tom Zunatobel
Chief Executive Officer

TAB 34

TAB 34

APEN (CIV)
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Attorneys for Unite Here Health and Nevada Health Solutions, LLC

DISTRICT COURT

CLARK COUNTY, NEVADA

STATE OF NEVADA, EX REL. COMMISSIONER OF INSURANCE, BARBARA D. RICHARDSON, IN HER OFFICIAL CAPACITY AS STATUTORY RECEIVER FOR DELINQUENT DOMESTIC INSURER,

Plaintiff,

v.

NEVADA HEALTH CO-OP,

Defendant.

Case No. A-15-725244-C
Dept. No. I

APPENDIX OF EXHIBITS TO UNITE HERE HEALTH AND NEVADA HEALTH SOLUTIONS, LLC'S MOTION TO:

(1) DISQUALIFY GREENBERG TRAURIG, LLP AS COUNSEL FOR THE STATUTORY RECEIVER OF NEVADA HEALTH CO-OP; AND

(2) DISGORGE ATTORNEY'S FEES PAID BY NEVADA HEALTH CO-OP TO GREENBERG TRAURIG, LLP

VOLUME 2 OF 2

Pursuant to EDCR 2.27(b), Unite Here Health and Nevada Health Solutions, LLC (collectively "UHH") file this Appendix of Exhibits to their Motion to: (1) Disqualify Greenberg Traurig, LLP As Counsel for the Statutory Receiver of Nevada Health CO-OP; and (2) Disgorge Attorney's Fees Paid by Nevada Health CO-OP to Greenberg Traurig, LLP.

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VOLUME 2 OF 2

DATED this 8th day of October, 2020.

BAILEY❖KENNEDY

By: /s/ Dennis L. Kennedy
JOHN BAILEY
DENNIS KENNEDY
JOSEPH A. LIEBMAN
Attorneys for Unite Here Health and Nevada Health Solutions, LLC

BAILEY❖KENNEDY
8984 SPANISH RIDGE AVENUE
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702.562.8820

CERTIFICATE OF SERVICE

I certify that I am an employee of BAILEY❖KENNEDY and that on the 8th day of October, 2020, service of the foregoing **APPENDIX OF EXHIBITS TO UNITE HERE HEALTH AND NEVADA HEALTH SOLUTIONS, LLC'S MOTION TO: (1) DISQUALIFY GREENBERG TRAURIG, LLP AS COUNSEL FOR THE STATUTORY RECEIVER OF NEVADA HEALTH CO-OP; AND (2) DISGORGE ATTORNEY'S FEES PAID BY NEVADA HEALTH CO-OP TO GREENBERG TRAURIG, LLP , VOLUME 2 OF 2** was made by mandatory electronic service through the Eighth Judicial District Court's electronic filing system on all parties with an email address on record in this case.

/s/ Sharon L. Murnane
Employee of BAILEY❖KENNEDY

BAILEY❖KENNEDY
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EXHIBIT 7

EXHIBIT 7

STATE OF NEVADA, EX REL. COMMISSIONER OF INSURANCE, BARBARA D. RICHARDSON, IN HER OFFICIAL CAPACITY AS RECEIVER FOR NEVADA HEALTH CO-OP,

Plaintiff,

v.

MILLIMAN, INC., a Washington Corporation; JONATHAN L. SHREVE, an Individual; MARY VAN DER HEIJDE, an Individual; MILLENNIUM CONSULTING SERVICES, LLC, a North Carolina Corporation; LARSON & COMPANY P.C., a Utah Professional Corporation; DENNIS T. LARSON, an Individual; MARTHA HAYES, an Individual; INSUREMONKEY, INC., a Nevada Corporation; ALEX RIVLIN, an Individual; NEVADA HEALTH SOLUTIONS, LLC, a Nevada Limited Liability Company; PAMELA EGAN, an Individual; BASIL C. DIBSIE, an Individual; LINDA MATTOON, an Individual; TOM ZUMTOBEL, an Individual; BOBBETTE BOND, an Individual; KATHLEEN SILVER, an Individual; UNITE HERE HEALTH, is a multi-employer health and welfare trust as defined in ERISA Section 3(37); DOES I through X inclusive; and ROE CORPORATIONS I-X, inclusive,

Defendants.

Case No. A-17-760558-C
Dept. No. XVI
In the District Court
Clark County, Nevada

Expert Report of:

Henry Miller, Ph.D.

October 2, 2020

Contents

1. Introduction

My name is Henry Miller, Ph.D. I am a Managing Director in the Health Analytics practice of Berkeley Research Group, LLC. I have worked on health care issues for almost 50 years. I have conducted studies on these issues for the federal Medicare program, State Medicaid programs and more than 40 health insurers. I have testified on these issues in the U.S. Congress, several State legislatures and in federal, state and local courts and in arbitrations.

2. Summary of Qualifications

I have worked on Federal health policy issues for most of my career, including issues related to the Federal government's role in funding and supporting private health insurance plans. This work began almost 50 years ago when the Department of Health and Human Services provided grants and technical assistance to Health Maintenance Organizations (HMOs). I led a technical assistance effort to establish and improve HMO financial management. I also worked with the Centers for Medicare and Medicaid Services (CMS) on several issues related to Medicare + Choice and Medicare Advantage (MA) plans, including assignments relating to the submission of claims and encounter data by plans and the development of CMS' risk adjustment formula for setting MA premiums. I subsequently worked with several insurers on MA plan issues.

My Federal health policy experience includes assignments for health agencies throughout the government, including the Health Resources and Services Administration, the National Center for Health Statistics, the National Institutes of Health, and the Agency for Healthcare Research and Quality. I also conducted several additional assignments for CMS.

My experience in working with health insurers and third-party administrators is also extensive. I have worked with more than 40 health plans, including most of the Nation's largest health insurers as well as most Blue Cross and Blue Shield plans. This work included evaluation of claims processing systems, design of benefit programs, development of provider networks and establishment of provider fee schedules and payment systems. I also worked with the Boards of Blue Cross and Blue Shield plans to evaluate management structures.

I have worked with third-party administrators (TPAs) on a variety of issues ranging from evaluations of marketing materials to reviews of claims processing issues and the development of provider payment approaches. This work was completed for TPAs in different regions of the U.S.

My experience in utilization management includes comprehensive reviews of utilization management approaches for Blue Cross and Blue Shield plans. In this work, I addressed the cost-benefit of specific approaches, including different aspects of pre-admission certification and determinations of medical necessity. I also assisted health insurers in structuring their utilization management functions and communicating their utilization management procedures and findings to providers.

My curriculum vitae is attached to this report as Appendix A.

3. Scope of Assignment

I was asked by the law firms of Seyfarth Shaw LLP and Bailey Kennedy to review materials and offer my expert opinions on issues related to the case of *State of Nevada, Ex Rel. Commissioner of Insurance, Barbara D. Richardson, in her Official Capacity as Receiver for Nevada Health CO-OP* (Plaintiff) *v. Milliman, Inc.* (Milliman)*; Jonathan L. Shreve; Mary Van Der Heijde; Millennium Consulting Services, LLC* (Millennium)*; Larson & Company, P.C.* (Larson)*; Dennis T. Larson; Martha Hayes; InsureMonkey, Inc.* (InsureMonkey or IM)*; Alex Rivlin; Nevada Health Solutions, LLC; Pamela Egan; Basil C. Dibsie; Linda Mattoon; Tom Zumtobel; Bobbette Bond; Kathleen Silver* (collectively NHC Management Defendants)*; and Unite Here Health* (collectively Defendants) (the Case).[1] My opinions are limited to two defendants: Unite Here Health (UHH) and Nevada Health Solutions (NHS). I was specifically asked to offer opinions on the cause of the failure of the Nevada Health CO-OP (NHC), whether UHH and/or NHS caused or was a substantial factor in bringing about the failure of NHC, as well as the reports prepared by Plaintiff's experts.[2,3]

BRG is receiving compensation for all work on this matter at hourly billing rates. BRG is compensated $750 per hour for Dr. Miller's services, and at rates between $160 per hour to $600 per hour for other BRG personnel, depending upon level and experience. BRG's compensation for work on this matter is not contingent upon the outcome of this matter or the opinions reached.

4. Background of Case

When the Patient Protection and Affordable Care Act (ACA) was enacted in 2010, it included a section on the establishment of Consumer Operated and Oriented Plans (commonly referred to as "cooperatives" or "CO-OPs" that would compete with health insurers to provide health coverage.[4] CO-OPs are private, nonprofit, state-licensed health insurance carriers.[5] Their plans are sold on either a state health insurance exchange or on the Federal health insurance exchange, commonly referred to as "exchanges" or "marketplaces." Most CO-OPs focus on providing coverage to individuals rather than groups.

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[1] Amended Complaint. State of Nevada, Ex Rel. v Milliman, Inc., et al. (September 24, 2018).

[2] Special Deputy Receiver's Report for Nevada Health CO-OP, Causation and Damages for Key Vendors Unite Here Health, Nevada Health Solutions, and InsureMonkey. PLAINTIFF02479813-02479851. (DRAFT SDR Report); Expert Report of Mark A. Fish, F.S.A., M.A.A.A., dated February 7, 2020. (Fish Report II); Expert Report of Henry William Osowski, dated February 7, 2020. (Osowski Report II); Expert Report of Joseph J. DeVito, dated July 30, 2019 (DeVito Report). It is unclear if the Fish Report II and Osowski Report II amend, supersede or supplement their initial reports from July 2019 (Osowski Report I and Fish Report I), therefore, my opinions are primarily responsive to the Fish Report II and Osowski Report II except when I discuss inconsistencies and/or overlap between the versions.

[3] I was also asked to assist in drawing random and representative samples of the following SDR claim number related damage categories: (1) DRAFT SDR Report's 2014 & 2015 Claims Overpayments, (2) DRAFT SDR Report's 2014 Claims Paid Outside of Eligibility (POE) and (3) DRAFT SDR Report's 2015 Claims POE. See Appendix B.

[4] 111th Congress. "Patient Protection and Affordable Care Act". Public Law 111–148, dated March 23, 2010. Section 1322(a)(1).

[5] 111th Congress. "Patient Protection and Affordable Care Act". Public Law 111–148, dated March 23, 2010. Section 1322(a)(2).

Originally, Congress expected to fund the CO-OP Program with $10 billion in grants, but this amount was reduced to $6 billion and rather than grants, the government made the money available as loans.[6] This change occurred as the Democratic majority House of Representatives became a Republican majority in the elections of 2010. In 2011 and 2012, funding was cut even further.[7] Eventually, a total of $2.4 billion in loans was awarded to the 23 CO-OPs that were part of the Federal CO-OP Program.[8] Most of these CO-OPs were newly established and used Federal funds to support their organizational activities.[9]

NHC was one of the newly established organizations. NHC was the successor to Hospitality Health, Ltd. (HH), which was established by the Culinary Health Fund (CHF) in 2011.[10] NHC began providing health coverage to Nevada residents on January 1, 2014 and ceased providing coverage on August 17, 2015, due to its deteriorating financial condition.[11] NHC was placed into receivership on September 25, 2015.[12] It did not have sufficient funds to meet the requirements of providers and insureds.[13]

NHC contracted with several vendors to perform many of its activities, including UHH for consulting[14] and third party administrative services,[15] and NHS for medical utilization review services.[16] UHH is a multi-employer Taft-Hartley Trust Fund that serves union employees in the hospitality, food service and

[6] Bash, D. and Barrett, T. "Negotiations over health insurance co-ops at impasse." CNNpolitics, dated June 23, 2009. Available at http://edition.cnn.com/2009/POLITICS/06/23/health.care/index.html?iref=newssearch. See also Redhead, S. C. "Appropriations and Fund Transfers in the Affordable Care Act (ACA)". Congressional Research Service, dated February 7, 2017, p. 6. Available at https://fas.org/sgp/crs/misc/R41301.pdf.
[7] Levinson, D. R. "Actual Enrollment and Profitability was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might affect Their Ability to Repay Loan Provided Under the Affordable Care Act". Department of Health and Human Services: Office of Inspector General, dated July 2015. A-005-14-00055, p. 12.
[8] Levinson, D. R. "Actual Enrollment and Profitability was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loan Provided Under the Affordable Care Act". Department of Health and Human Services: Office of Inspector General, dated July 2015. A-005-14-00055, p. ii.
[9] Levinson, D. R. "Actual Enrollment and Profitability was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loan Provided Under the Affordable Care Act". Department of Health and Human Services: Office of Inspector General, dated July 2015. A-005-14-00055, p. i.
[10] Amended Complaint, State of Nevada, Ex Rel. v. Milliman, Inc., et al. (September 24, 2018). ¶ 3.
[11] Amended Complaint, State of Nevada, Ex Rel. v. Milliman, Inc., et al. (September 24, 2018). ¶ 4.
[12] Amended Complaint, State of Nevada, Ex Rel. v. Milliman, Inc., et al. (September 24, 2018). ¶ 5.
[13] Amended Complaint, State of Nevada, Ex Rel. v. Milliman, Inc., et al. (September 24, 2018). ¶ 8.
[14] Consulting Agreement between Unite Here Health and Hospitality Health, Ltd., dated January 30, 2013. UHH0000041-UHH0000065; Letter from Jeff Ellis, Director and Co-Chair of Nevada Health CO-OP and Hospitality Health Ltd. to Matthew Walker, CEO of Unite Here Health regarding Assignment of Consulting Agreement from Hospitality Health, Ltd. to Nevada Health CO-OP, dated May 8, 2013. UHH0000066; Letter of Clarification regarding the Consulting Agreement, dated May 16, 2013. UHH0000067. (Consulting Agreement)
[15] Administrative Services Agreement between Unite Here Health and Nevada Health CO-OP, dated on June 27, 2013 and Amendments and Agreement Letters. UHH0000001-UHH0000039. (ASA)
[16] Utilization Management Services Agreement between Nevada Health CO-OP and Nevada Health Solutions, LLC, dated July 19, 2013. NHS0000001-NHS0000100. Business Associate Agreement between Nevada Health Solutions and Nevada Health CO-OP, effective October 1, 2013. NHS0000101-NHS0000117. Termination Letter from Kathy Silver, President of NHS, to Tom Zumtobel, Chief Executive Officer of NHC, Regarding Utilization Management Services Agreement dated as of July 19, 2013 between Nevada Health CO-OP ("CO-OP") and NHS, as amended (the "Agreement"), dated October 23, 2014. NHS0000118.

gaming industries.[17] NHS is a URAC accredited provider of medical management services including pre-admission certification, concurrent review, and case management.[18]

Plaintiff alleges that UHH and NHS caused or substantially contributed to the failure of NHC. Specifically, Plaintiff alleges that UHH failed to properly assure the eligibility of insureds, paid claims for which insureds were not eligible, did not properly report insurance data and mishandled recordkeeping and computer systems.[19] In addition, Plaintiff alleges that NHS did little work for NHC and was paid unfairly due to its capitation agreement.[20]

Defendants UHH and NHS deny all of Plaintiff's allegations.[21] As discussed in subsequent sections of this report, it is clear that UHH and NHS did not cause or substantially contribute to the failure of NHC. Instead, NHC failed because the Federal CO-OP program failed and because NHC's claims costs substantially exceeded its premium revenue, and due to various operational issues unrelated to the actions of UHH and NHS.[22]

5. Summary of Opinions

A summary of my primary opinions, which I discuss in detail in this report, are as follows:

- The Federal ACA program systematically failed, causing the collapse/failure of NHC as well as 18 other CO-OPs[23];
- UHH and/or NHS did not cause the failure of NHC nor were they (either individually or collectively) a substantial factor in bringing about NHC's failure, damages or losses. Instead, like other CO-OPs across the U.S., NHC failed because its claims cost exceeded its premium revenue and because the Federal Government failed to provide expected financial support;
- Plaintiff's experts fail to demonstrate that UHH and/or NHS caused the failure of NHC; and
- Plaintiff's experts' opinions regarding damages are seriously flawed.

[17] Unite Here Health. "Mission & Overview". Available at https://www.uhh.org/about.
[18] Nevada Health Solutions. "About Nevada Health Solutions". Available at https://www.nevadahealthsolutions.org/about/. See also URAC Certificate of Full Accreditation awarded to NHS effective First Friday of November 2013 to First Tuesday of November 2016. Certificate Number: U130019-3546. NHS0000658. "URAC was originally incorporated under the name Utilization Review Accreditation Commission." See https://www.urac.org/accreditation-faqs.
[19] Amended Complaint. State of Nevada, Ex Rel. v Milliman, Inc., et al. (September 24, 2018). ¶31.
[20] Amended Complaint. State of Nevada, Ex Rel. v Milliman, Inc., et al. (September 24, 2018). ¶38.
[21] Nevada Health Solutions, LLC's Answer to Amended Complaint. State of Nevada, Ex Rel. v. Milliman, Inc., et al. (July 30, 2019). ¶ 4. Unite Here Health's Answer to Amended Complaint. State of Nevada, Ex Rel. v. Milliman, Inc., et al. (October 22, 2018). ¶ 4.
[22] The operational issues are specifically addressed in the Expert Report of Christina Melnykovych and Tina Pelton, Coding Continuum, Inc. dated October 2, 2020 (CCI Report) as well as in this report.
[23] A 19th CO-OP, New Mexico Health Connections, has announced that it has also failed and will cease operations on December 31, 2020.

In forming my opinions, I was assisted by BRG professionals and other consulting professionals working under my direction. A list of data and documents relied upon in forming my opinions is presented in Appendix C.

6. The Federal Affordable Care Act (ACA) CO-OP Program Failed

In my opinion, NHC failed for reasons that are unrelated to the activities of UHH and NHS. Specifically, it is critically important to understand that the Federal CO-OP Program failed. NHC was one of 23 CO-OPs that were funded with loans from the Federal CO-OP Program. All 23 CO-OPs experienced serious financial problems. Eighteen of the 23 CO-OPs failed within the same time frame as NHC and none of those 18 CO-OPs used UHH and/or NHS. An additional CO-OP (New Mexico Health Connections) announced that it is closing at the end of 2020. This CO-OP also did not use UHH and/or NHS. As of the date of this report, the remaining CO-OPs have struggled to maintain their financial viability. While the failure of the Federal CO-OP Program was undeniably the primary cause of NHC's failure, additional factors that contributed to NHC's failure are discussed in subsequent sections and in the CCI Report.

6.1 Overview of the Affordable Care Act

The ACA was enacted in 2010.[24] A key goal of the ACA was to "make affordable health insurance available to more people."[25] "Between 2013 and 2016, the number of uninsured individuals in Nevada declined from 570,000 to 330,000, a 42.1 percent decrease."[26] The ACA made many reforms to the individual insurance market such as[27]:

- Requiring guaranteed coverage of pre-existing health conditions;
- Adding coverage of preventive health services and essential health benefits;
- Ending lifetime limits on coverage;
- Limiting community rating based on age;
- Providing subsidies; and
- Establishing an individual penalty for not having health insurance.

Aspects of the ACA are especially relevant to this case. For example, a key intent of the ACA was to make coverage available and affordable for people with preexisting conditions.[28] People with

[24] 111th Congress. "Patient Protection and Affordable Care Act". Public Law 111–148, dated March 23, 2010.
[25] HealthCare.gov. "Affordable Care Act (ACA)". Available at https://www.healthcare.gov/glossary/affordable-care-act/.
[26] Ballotpedia. "Effect of the Affordable Care Act in Nevada". Available at https://ballotpedia.org/Effect_of_the_Affordable_Care_Act_in_Nevada.
[27] 111th Congress. "Patient Protection and Affordable Care Act". Public Law 111–148, dated March 23, 2010. Section 1501.
[28] HealthCare.gov. "Coverage for pre-existing conditions". Available at https://www.healthcare.gov/coverage/pre-existing-conditions/. Department of Human & Health Services. "Pre-Existing Conditions". Available at https://www.hhs.gov/healthcare/about-the-aca/pre-existing-conditions/index.html. See also CCIIO. "At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform". CMS. Available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-

preexisting conditions could get coverage if they were members of a large employer group, but coverage was not available for their preexisting conditions if they needed to pursue individual or small group coverage.[29] As a result, a substantial portion of the population that the ACA was aimed at was assumed to be sicker than the general population. To counteract the risk associated with providing coverage to a sicker population, the ACA included an "individual mandate" that required everyone to have health coverage or pay a penalty.[30] There was little data available, however, on the extent of use of medical services by the sicker population or the number of people who would choose to pay a penalty rather than purchase health coverage. Entities that elected to offer coverage, such as NHC and the other CO-OPs that were funded under the ACA, did not have a database they could use to make accurate actuarial projections of medical use in order to set premiums.

The ACA also created a new environment in which coverage was to be sold. Each state was given an opportunity to create its own health insurance exchange or elect to use the Federal exchange.[31] Coverage providers made their policies available on the exchanges and individuals seeking to purchase coverage could choose among them. Health insurance exchanges were a new idea that needed to be established quickly to meet the ACA's requirements for offering coverage by the beginning of 2014.[32] Exchanges needed to establish systems for determining eligibility for coverage, for determining the availability of financial support on an individual level, and for reporting enrollment to insurance carriers who offered policies on the exchange. Although funding was available for establishing exchanges, many exchanges struggled with implementation requirements in the short time frame that was available to them.

As noted, the ACA included a section on the establishment of private, non-profit cooperatives (CO-OPs) that would compete with health insurers to provide health coverage.[33] These CO-OP plans were sold on state health insurance exchanges or on the Federal health insurance exchange.

Resources/preexisting. ("The Center for Consumer Information and Insurance Oversight (CCIIO) is charged with helping implement many reforms of the Affordable Care Act, the historic health reform bill that was signed into law March 23, 2010. CCIIO oversees the implementation of the provisions related to private health insurance. In particular, CCIIO is working with states to establish new Health Insurance Marketplaces." Available at https://www.cms.gov/CCIIO)

[29] Rovner, J. "Did the ACA Create Preexisting Condition Protections for People In Employer Plans?". Kaiser Health News, dated May 21, 2019. Available at https://khn.org/news/did-the-aca-create-preexisting-condition-protections-for-people-in-employer-plans/.

[30] Rosso, R. J. "The Individual Mandate for Health Insurance Coverage: In Brief". Congressional Research Service, updated on August 25, 2020, p. 1. Available at https://fas.org/sgp/crs/misc/R44438.pdf.

[31] Forsberg, V. C., "Overview of Health Insurance Exchanges". Congressional Research Service. June 20, 2018. Available at https://fas.org/sgp/crs/misc/R44065.pdf.

[32] 111th Congress. "Patient Protection and Affordable Care Act". Public Law 111–148, dated March 23, 2010. Section 1321(b).

[33] 111th Congress. "Patient Protection and Affordable Care Act". Public Law 111–148, dated March 23, 2010. Section 1322(a)(1).

6.2 The CO-OP Program Failed Due to Market-Based Issues and the Failure of the Federal Government to Provide Expected Support

The Federal CO-OP program is widely seen as a failure that is generally attributed to market-based and legislative issues.[34] Nineteen of 23 federally funded CO-OPs, including NHC, failed prior to 2020 and one CO-OP failed in 2020, which equates to an overall 87 percent failure rate.[35] All 23 federally funded CO-OPs started selling insurance contracts at the beginning of 2014.[36] By the end of 2015, over half of all CO-OPs (12 total) had failed (including NHC) and five more CO-OPs failed in 2016.[37] Two failed in 2017.[38] One failed in 2020.[39] As of the date of this report, the remaining three that are operating have experienced financial difficulties. As discussed in the sections below, several reasons are cited as being responsible for the failure of the Federal CO-OP Program,[40] including:

- Claims Costs Exceeded Premium Revenue;
- Congressional and Regulatory Changes Destabilized the CO-OP Program;
- The CO-OPs Were Disadvantaged Compared to Their Commercial Competitors; and
- The ACA's 3 R's Failed to Protect CO-OPs from Substantial Losses.

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[34] U.S. Government Publishing Office. "Review of the Affordable Care Act health insurance Co-Op Program: Hearing Before the Permanent Subcommittee on Investigations of the Committee on Homeland Security and Governmental Affairs". United States Senate, One Hundred Fourteenth Congress, Second Session, dated March 10, 2016, pp. 1-2. See also Corlette, S.; Miskell, S.; Lerche, J.; and Giovannelli, J. "Why Are Many CO-Ops Failing? How New Nonprofit Health Plans Have Responded to Market Competition", The Commonwealth Fund, dated December 2015, p. 7. Available at https://www.commonwealthfund.org/publications/fund-reports/2015/dec/why-are-many-co-ops-failing-how-new-nonprofit-health-plans-have.

[35] See Table 2. See also: New Mexico Health Connections. "New Mexico Health Connections, Non-Profit Health Insurer, to Cease Operations in 2021". PRNewswire, dated August 11, 2020. https://www.prnewswire.com/news-releases/new-mexico-health-connections-non-profit-health-insurer-to-cease-operations-in-2021-301110358.html.

[36] Levinson, D. R. "Actual Enrollment and Profitability was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loan Provided Under the Affordable Care Act". Department of Health and Human Services: Office of Inspector General, dated July 2015. A-005-14-00055, p. ii.

[37] Jarmon, G. L. "CMS Oversight Must Continue Because All Remaining Consumer Operated and Oriented Plans Were Not Profitable and May Not Be Viable and Sustainable". Department of Health and Human Services: Office of Inspector General, dated August 2017. A-05-16-00027, p. 1.

[38] Evergreen Health Cooperative (MD) was "unable to offer or bind any new individual policies during Open Enrollment for the 2017 plan year (for policies effective January 1, 2017)" and was "prohibited from selling or renewing any insurance policies" in July 2017. See https://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2016122 and https://insurance.maryland.gov/Consumer/Documents/Evergreen/Evergreen-Order-Release-7272017.pdf. Minuteman Health, Inc. (MA) stopped writing business as of January 1, 2018. See https://www.nh.gov/insurance/media/pr/2017/documents/06-23-17-nhid-minuteman-to-stop-offering-insurance-in-2018.pdf.

[39] New Mexico Health Connections. "New Mexico Health Connections, Non-Profit Health Insurer, to Cease Operations in 2021". PRNewswire, dated August 11, 2020. Available at https://www.prnewswire.com/news-releases/new-mexico-health-connections-non-profit-health-insurer-to-cease-operations-in-2021-301110358.html.

[40] Corlette, S.; Miskell, M.; Lerche, J.; and Giovannelli, J. "Why Are Many CO-Ops Failing? How New Nonprofit Health Plans Have Responded to Market Competition". The Commonwealth Fund, dated December 2015, pp. 7-8. Available at https://www.commonwealthfund.org/publications/fund-reports/2015/dec/why-are-many-co-ops-failing-how-new-nonprofit-health-plans-have.

6.3 CO-OPs' Claims Costs Exceeded Premium Revenue

As discussed, a primary goal of the ACA was to "make affordable health insurance available to more people."[41] But, "the law's elimination of medical underwriting and health-rating restrictions, and its limits on age rating, have made the market more attractive to older, sicker people."[42] In a report prepared by the Society of Actuaries, the authors described the significance of this and related issues. They noted that in the national individual market, per member per month claims costs rose by approximately 38.0 percent from 2013 to 2014 and then by an additional 30.0 percent from 2014 to 2015.[43] The reasons cited for the increase were:

> "Individual market PMPM claims costs essentially doubled from 2009–2015. The bulk of this increase took place in 2014 and 2015 with the inclusion of ACA Health Insurance Exchange experience…This was driven by the elimination of medical underwriting and the advent of covering preexisting conditions, which had generally not been covered in previous Individual plans. In addition to this, there were large benefit plan design changes where benefits previously not required and often not covered under the old individual policies were now required to be covered as part of the ACA EHBs. Finally, the shifting of membership toward higher age brackets with greater costs also contributed to PMPM increases."[44]

In late 2013, after insurers had already started marketing 2014 plans, CMS announced a transitional relief measure where states could allow individuals and small groups to keep their 2013 ACA-non-compliant plans.[45] The non-compliant ACA plans, or grandfathered plans, were not required to offer free preventive care, end yearly limits on coverage, or cover people with pre-existing health conditions.[46] The CO-OPs' 2014 membership projections and premiums were set well before CMS implemented these transitional relief measures which effectively limited the likelihood that healthy individuals and small groups would enter the ACA risk pool. The negative impact on CO-OPs was substantial because many plans attracted fewer healthy members, and a large number of sicker members. For example,

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[41] HealthCare.gov. "Affordable Care Act (ACA)". Available at https://www.healthcare.gov/glossary/affordable-care-act/.

[42] Glied, S. A. and Jackson, A. "Who Entered and Exited the Individual Health Insurance Market Before and After the Affordable Care Act? Evidence from the Medical Expenditure Panel Survey". The Commonwealth Fund, dated November 29, 2018. Available at https://www.commonwealthfund.org/publications/issue-briefs/2018/nov/who-entered-exited-insurance-market-before-after-aca.

[43] Natsis, A.; Owen, R.; Hargraves, J.; and Hui, A. "Commercial Health Care Cost and Utilization Trends, 2009-2015". Society of Actuaries®, p. 16. Available at https://www.healthcostinstitute.org/images/pdfs/2019-commerical-health-care-cost-utilization-trends-report.pdf.

[44] Natsis, A.; Owen, R.; Hargraves, J.; and Hui, A. "Commercial Health Care Cost and Utilization Trends, 2009-2015". Society of Actuaries®, p. 16. Available at https://www.healthcostinstitute.org/images/pdfs/2019-commerical-health-care-cost-utilization-trends-report.pdf

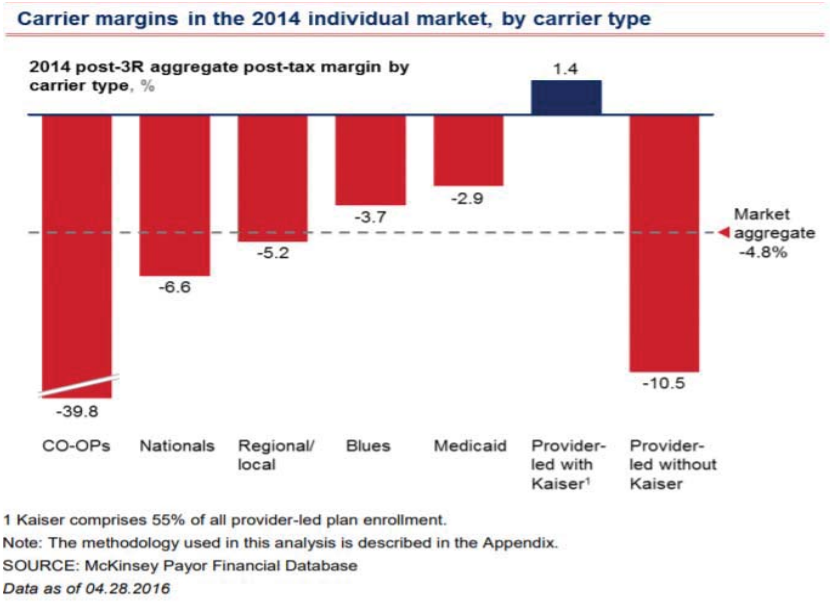
[45] CCIIO. " Letter from Gary Cohen, Director of CCIIO, to Insurance Commissioners". CMS, dated on November 14, 2013. Available at https://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.

[46] HealthCare.gov. "Health insurance rights & protection: Grandfathered health insurance plans". Available at https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/.

> "In Iowa, most of the Wellmark (BCBS) market share continues to be in non-compliant plans (the grandmothered/grandfathered pre-ACA plans), so Wellmark cherry picks its own market share. Over three years, news reports show Wellmark lost $90 million on ACA compliant plans, with one enrollee accounting for $18 million in claims for one year alone. So, for 2018, Wellmark will not only leave the marketplace, it will stop offering all ACA compliant plans, keeping in force just their pre-ACA policies."[47]

This is exactly what happened during the 2014 enrollment year. Enrollment in CO-OP plans was generally lower than initial projections and claims expense exceeded premium revenue.[48] Most of the CO-OPs had lower than projected actual enrollment.[49] "For 19 of the 23 CO-OPs with net losses, claims expense exceeded premium revenue for this period. The remaining CO-OPs with net losses reported higher premium revenues than claims expense, but revenue was insufficient to meet general administrative expenses."[50] According to the McKinsey Center for U.S. Health System Reform, CO-OPs were the least profitable carrier type in 2014.[51]

[47] Khazan, O. "Why So Many Insurers Are Leaving Obamacare". The Atlantic, dated on May 11, 2017. Available at https://www.theatlantic.com/health/archive/2017/05/why-so-many-insurers-are-leaving-obamacare/526137/.
[48] Levinson, D. R. "Actual Enrollment and Profitability was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loan Provided Under the Affordable Care Act". Department of Health and Human Services: Office of Inspector General, dated July 2015. A-005-14-00055, p. 8.
[49] Levinson, D. R. "Actual Enrollment and Profitability was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loan Provided Under the Affordable Care Act". Department of Health and Human Services: Office of Inspector General, dated July 2015. A-005-14-00055. Table 1.
[50] Levinson, D. R. "Actual Enrollment and Profitability was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loan Provided Under the Affordable Care Act". Department of Health and Human Services: Office of Inspector General, dated July 2015. A-005-14-00055, p. 8.
[51] McKinsey & Company. "Exchanges three years in: Market variations and factors affecting performance". McKinsey Center for U.S. Health System Reform, updated as of May 13, 2016. Exhibit 2, p. 3. Available at https://healthcare.mckinsey.com/sites/default/files/Intel%20Brief%20-%20Individual%20Market%20Performance%20and%20Outlook%20(public)_vF.pdf.



In my opinion, unexpected high claims costs occurred because of the difficulty that all insurers had with projecting claims costs for a population that was different than populations that had been insured in the past. This problem was discussed frequently in the industry literature.[52] The majority of the people seeking coverage on the exchanges were previously uninsured. Although people who had coverage through an employer of at least one member of a family may have had group coverage, there was no data source to identify the claims costs of the uninsured population. This was especially true for the CO-OPs that had no claims data available to them when they began offering health coverage in 2014.

6.4 Congressional and Regulatory Changes Destabilized the CO-OP Program

Both Congress and the Executive Branch instituted substantial changes to the CO-OP program after the ACA was passed. These changes limited funding for the CO-OPs and established policies that limited and/or eliminated their opportunities for success.

As mentioned, the ACA initially set aside $10 billion in grants for CO-OP activities.[53] When the program was passed, however, the $10 billion was reduced to $6 billion and the funds were to be distributed as loans rather than grants.[54] Two types of loans were established – loans for starting up operations and loans to meet financial solvency requirements of State Insurance Departments.[55]

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[52] See, for example, https://www.healthinsurance.org/maine-state-health-insurance-exchange/, and https://www.healthinsurance.org/montana-state-health-insurance-exchange/.
[53] Bash, D. and Barrett, T. "Negotiations over health insurance co-ops at impasse." CNNpolitics, dated June 23, 2009. Available at http://edition.cnn.com/2009/POLITICS/06/23/health.care/index.html?iref=newssearch.
[54] Redhead, S. C. "Appropriations and Fund Transfers in the Affordable Care Act (ACA)". Congressional Research Service dated February 7, 2017, p. 6. Available at https://fas.org/sgp/crs/misc/R41301.pdf.
[55] CCIIO. "New Federal Loan Program Helps Nonprofits Create Customer-Driven Health Insurers". CMS. Available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/coop_final_rule.

The $6 billion in funding was further reduced before the ACA was implemented. In 2011 and 2012, appropriations bills that were passed reduced the funding level to $3.4 billion.[56] At the end of 2012, CO-OP funding was reduced again under the American Taxpayer Relief Act.[57] In 2013, some funds were sequestered, and CMS ended up awarding only $2.5 billion in loans to CO-OPs, a 76% reduction from the initial level.[58]

As discussed, CO-OPs faced a substantial challenge in 2013 when the Administration announced that insurers could wait to cancel plans not in compliance with the ACA.[59] As a result, at least some healthier people who liked their current plans continued to purchase them outside of exchanges, which meant that enrollees purchasing coverage on the exchanges were sicker and, therefore, more costly than expected.

The ACA also built in methods to limit risk assumed by the CO-OPs.[60] One of these provisions was the risk-corridor program which redistributed funds from insurers who exceeded their target to insurers who had made less than their target.[61] In 2014, after CO-OPs were up and running, the new Congress required the program to be budget-neutral and as a result, the Administration indicated that only 12.6 percent of the funds originally expected to be available for risk corridor payments would actually be available to CO-OPs to continue their operations.[62] (In other words, CO-OPs received only 12.6 percent of the Federal funds they were originally promised, expected, and relied upon to subsidize their losses.) Many CO-OPs were already in critical financial condition and this reduction by Congress assured their failure.

Some CO-OPs challenged the Administration's actions on reducing risk corridor payments in court and on April 27, 2020, the United States Supreme Court issued its decision in *Maine Community Health*

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[56] Redhead, S. C. "Appropriations and Fund Transfers in the Affordable Care Act (ACA)". Congressional Research Service dated February 7, 2017, p. 9. Available at https://fas.org/sgp/crs/misc/R41301.pdf.
[57] Redhead, S. C. "Appropriations and Fund Transfers in the Affordable Care Act (ACA)". Congressional Research Service dated February 7, 2017, p. 9. Available at https://fas.org/sgp/crs/misc/R41301.pdf.
[58] CCIIO. "Loan Program Helps Support Customer-Driven Non-Profit Health Insurers". CMS, updated on December 16, 2014. Available at https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program. See also Redhead, S. C. "Appropriations and Fund Transfers in the Affordable Care Act (ACA)". Congressional Research Service dated February 7, 2017, p. 9. Available at https://fas.org/sgp/crs/misc/R41301.pdf.
[59] CCIIO. "Letter from Gary Cohen, Director of CCIIO, to Insurance Commissioners". CMS, dated on November 14, 2013. Available at https://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.
[60] CCIIO. "Reinsurance, Risk Corridors, and Risk Adjustment Final Rule". CMS, dated March 2012. Available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/3rs-final-rule.pdf.
[61] Cox, C.; Semanskee, A.; Claxton, G.; and Levitt, L. "Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors". Kaiser Family Foundation, dated August 17, 2016. Available at https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/.
[62] CCIO. "Risk Corridors Payment Proration Rate for 2014". CMS, dated October 1, 2015. Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf.

Options v. United States.[63] The decision concluded that the government was, and now is, obligated to pay an additional $12 billion in risk corridor payments.[64] The Supreme Court was clear in its opinion that the Federal government was obligated to pay the disputed funds to the CO-OPs, but its decision comes years after the vast majority of CO-OPs had already failed.

In my opinion, the substantial difference in funding by the Government between the CO-OPs' original expectations and the amounts actually made available to them led to the destabilization of the Federal CO-OP Program and was a substantial factor in bringing about the CO-OPs' failures, including the failure of NHC.

6.5 The CO-OPs Were Disadvantaged Compared to Their Commercial Competitors

The CO-OPs were disadvantaged compared to their commercial competitors in many key aspects. Starting a health insurance company is complex. First, CO-OPs had very short start-up periods. Loans were awarded in 2012 for a January 1, 2014 start date.[65] Short start-up periods meant decisions on benefit design and premium rate settings had to be made quickly with little available data to project enrollment and costs likely to be incurred by members. Further, coverage was primarily offered to individuals, many of whom had not had coverage previously. In addition, most CO-OPs were facing substantial competition from established insurers and had to set premiums at the same or lower levels than their competitors in order to gain enrollment.[66]

CO-OPs were told that their success depended, in part, on their ability to participate in the first open enrollment period offered by the Health Insurance Exchanges which was occurring at the end of 2013.[67] In its final report, the Federal Advisory Board on the Consumer Operated and Oriented Plan Program recommended that:

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[63] Supreme Court of the United States. Maine Community Health Options v. United States, 590 U. S. ___ (2020). Nos. 18-1023, 18-1028, 18-1038.

[64] Keith, K. "Supreme Court Rules That Insurers are Entitled to Risk Corridors Payments: What the Court Said and What Happens Next". Health Affairs Blog, dated April 28, 2020. DOI: 10.1377/hblog20200427.34146/full/. Available at https://www.healthaffairs.org/do/10.1377/hblog20200427.34146/full/.

[65] Levinson, D. R. "The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance With Federal Requirements, and Continued Oversight is Needed". Department of Health and Human Services: Office of Inspector General, dated July 2013. A-005-12-00043. Available at https://oig.hhs.gov/oas/reports/region5/51200043.pdf. See also CCIIO. "Loan Program Helps Support Customer-Driven Non-Profit Health Insurers". CMS, updated on December 16, 2014. Available at https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.

[66] Corlette, S.; Miskell, M.; Lerche, J.; and Giovannelli, J. "Why Are Many CO-Ops Failing? How New Nonprofit Health Plans Have Responded to Market Competition". The Commonwealth Fund, dated December 2015, p. 7. Available at https://www.commonwealthfund.org/publications/fund-reports/2015/dec/why-are-many-co-ops-failing-how-new-nonprofit-health-plans-have.

[67] CCIIO. "Report of the Federal Advisory Board on the Consumer Operated and Oriented Plan (CO-OP) Program". CMS, dated April 15, 2011, pp. 15 & 37. Available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/coop_faca_finalreport_04152011.pdf.

> "The Advisory Board recognizes that the need to compete for plan membership means that it will be highly desirable for new CO-OP plans to be ready to enroll members during the first open enrollment period offered by Health Benefit Exchanges. The Advisory Board also recognizes the amount of work and length of time required for CO-OPs to be able to be open for business on this timetable. In order to provide funding for CO-OPs to be ready to accept enrollment in late 2013, the Department should issue draft regulations in Spring 2011. It should issue final regulations and the loan/grant solicitation in Summer 2011, with the capability to receive and review applications in Fall 2011. Because participation in the Health Benefit Exchange is essential to CO-OP viability and the ability to repay loans and grants, a CO-OP should be able to participate in its state's Exchange regardless of the Exchange model adopted in the state."[68]

The Federal government's CO-OP Advisory Board recognized that CO-OPs' financial viability required start-up activities to be completed in less than two years, especially if start-up loans were to be repaid in five years. At the time that the Advisory Board's report was issued, the Board expected $6 billion in loans to be available. As previously discussed, only $2.4 billion was actually made available to CO-OPs.

Other issues also constrained the CO-OPs' operations; namely:

- CO-OPs had limited access to external capital sources. By mid-2016, HHS recognized that CO-OPs had "encountered challenging market conditions in their early years" and that "in the absence of additional Federal loans to CO–OPs, many of these entities would benefit from the infusion of private capital to assist them in achieving long-term stability and competitive success in the market."[69] Initially, "entities offering loans, investments, and services to participate on the board of directors, as is common practice in the private sector" and equity interests could not be offered to equity investors, making it nearly impossible for CO-OPs to access private capital. Effective in May 2016, HHS amended CO-OP requirements to "provide CO–OPs with flexibility common among private market health insurance issuers,"[70] but the changes came too late for many of the CO-OPs. Additionally, "substantially all" of the CO-OPs' business must be in the individual and small-group insurance markets,[71] which meant they could not access the profitable large employer market dominated by their commercial competitors.

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[68] CCIIO. "Report of the Federal Advisory Board on the Consumer Operated and Oriented Plan (CO-OP) Program". CMS, dated April 15, 2011, p. 20. Available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/coop_faca_finalreport_04152011.pdf.

[69] Department of Health and Human Services. "45 CFR Parts 155 and 156: Patient Protection and Affordable Care Act; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program". Federal Register, Vol. 81, No. 91, effective on May 11, 2016, p. 29148. Available at https://www.govinfo.gov/content/pkg/FR-2016-05-11/pdf/2016-11017.pdf.

[70] Department of Health and Human Services. "45 CFR Parts 155 and 156: Patient Protection and Affordable Care Act; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program". Federal Register, Vol. 81, No. 91, effective on May 11, 2016, p. 29148. Available at https://www.govinfo.gov/content/pkg/FR-2016-05-11/pdf/2016-11017.pdf.

[71] Department of Health and Human Services. "45 CFR Part 156: Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program". Federal Register, Vol. 76, No. 239,

- CO-OPs were prohibited from using federal funds to market their policies. As noted, for most of the CO-OPs, including NHC, there were few other sources of capital and their marketing activities were severely constrained at a time when competing insurers were actively offering individual policies on state health insurance exchanges without limitations on their marketing efforts.[72]

- The ACA introduced medical loss ratio limits for all insurers, but these limits especially (adversely) affected CO-OPs. The ACA required health insurers to retain no more than 20 percent of their premium revenues for administrative expenses and surplus.[73] More mature insurers had significant reserves that allowed them to address this constraint, but start-up organizations like CO-OPs had no such resources. This constraint further limited CO-OPs' ability to meet their capital needs.

- ACA legislation prohibited CO-OPs from including any person with current health insurance experience on their boards.[74] Although the intent of the prohibition appeared to be encouragement of consumer participation in the CO-OPs, it created a limitation by excluding important expertise that could help support the CO-OPs' operations.

- A mature insurer has data that can be used to both project enrollment and set premium rates. CO-OPs did not have access to such data. If they set premium rates too high, they would obtain less enrollment which would mean that their capability to retain capital to pay back their start-up loan was limited. If they set premium rates too low, they would experience greater enrollment but face much higher risk that they would attract sicker members who would require higher claim payments. Mature insurers have both reserves to offset these potential problems and data that allow them to accurately predict premium rates. CO-OPs, however, were at a significant disadvantage without the data that their competitors had.[75] Mature insurers had data

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effective December 13, 2011. 45 CFR § 156.515(c)(1), p. 77413. Available at https://www.govinfo.gov/content/pkg/FR-2011-12-13/pdf/FR-2011-12-13.pdf.

[72] Corlette, S.; Miskell, M.; Lerche, J.; and Giovannelli, J. "Why Are Many CO-Ops Failing? How New Nonprofit Health Plans Have Responded to Market Competition". The Commonwealth Fund, dated December 2015, p. 7. Available at https://www.commonwealthfund.org/publications/fund-reports/2015/dec/why-are-many-co-ops-failing-how-new-nonprofit-health-plans-have.

[73] Department of Health and Human Services. "Title 45: Public Welfare". Federal Register, revised as of October 1, 2011. 45 CFR § 158.210, p. 790. Available at https://www.govinfo.gov/content/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-sec158-210.pdf. See also CCIIO. "CCIIO Examinations, Audits and Reviews of Issuers: Issuer Resources". CMS. Available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Exams_Audits_Reviews_Issuer_Resources-.

[74] Department of Health and Human Services. "45 CFR Parts 153, 155, 156, et al." Federal Register, Vol. 76, No. 239. effective December 13, 2011. 45 CFR § 156.515(b)(2)(v); 45 CFR § 156.510(b)(1)(i); 45 CFR § 156.505, pp. 77412 & 77413. Available at https://www.govinfo.gov/content/pkg/FR-2011-12-13/pdf/2011.-.

[75] Corlette, S.; Miskell, M.; Lerche, J.; and Giovannelli, J. "Why Are Many CO-Ops Failing? How New Nonprofit Health Plans Have Responded to Market Competition". The Commonwealth Fund, dated December 2015, p. 7.

on the number of high-risk members in their group lines of business as well as the cost of their claims. They were better prepared to establish appropriate premium rates, although as discussed elsewhere in this report, they also underestimated claims costs. It is obvious that mature insurers had substantial reserves that allowed them to absorb losses in the first year of offering products on the Exchanges. Insurers such as United Healthcare, Aetna and Humana had hundreds of millions of dollars in reserves while their exchange products represented only a small portion of their total insured members.[76] In contrast, most CO-OPs' only source of reserves were Federal loans.

- All states have risk-based capital (RBC) requirements for insurance companies doing business in their state. "RBC limits the amount of risk a company can take"[77] and helps to ensure that a health insurance company has enough money to pay its medical claims. CMS recognized that "in most states, sufficient RBC levels are between 200 percent and 300 percent" but that the "CO-OP Loan Agreement requires a CO-OP to maintain a surplus level of 500 percent Risk-Based Capital (RBC)" and failure to do could result in a default under the loan.[78,79] As discussed, the CO-OPs already had limited access to external capital sources unlike their commercial competitors and increased RBC requirements put the CO-OPs at a further financial disadvantage.

- The short time frame available for CO-OPs to initiate operations also required them to outsource key aspects of their operations.[80] It is for this reason that most CO-OPs (like NHC) turned to contracts with third-party administrators (TPAs) and utilization management companies rather than attempting to initially build their own claims processing and review systems.

- Several CO-OPs (including NHC) incurred increased information technology costs due to technical issues. For example, CMS expected CO-OPs to process the substantial majority of claims electronically, but limitations caused, in part, by the technical issues faced by the

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Available at https://www.commonwealthfund.org/publications/fund-reports/2015/dec/why-are-many-co-ops-failing-how-new-nonprofit-health-plans-have.

[76] 2015 Forms 10-K for United Health Group Inc., Aetna Inc. /PA/ and Humana Inc. United States Securities and Exchange Commission. Available at https://www.sec.gov/.

[77] The Center for Insurance Policy and Research. "Risk-Based Capital". National Association of Insurance Commission, updated June 24, 2020. Available at https://content.naic.org/cipr_topics/topic_risk_based_capital.htm.

[78] CCIIO. "Frequently Asked Questions on the Consumer Operated and Oriented Plan (COOP) Program" CMS, dated on January 27, 2016, p. 2. Available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CO-OP-Questions-Final-1-27-16.pdf.

[79] CCIIO. "CO-OP Program Guidance Manual". CMS, dated July 29, 2015. Version 1, p. 45. Available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CO-OP-Guidance-Manual-7-29-15-final.pdf.

[80] Levinson, D. "Early Implementation of the Consumer Operated and Oriented Plan Loan Program". Department of Health and Human Services: Office of Inspector General, dated July 2013. OEI-01-12-00290. Available at https://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf.

exchanges, led to the need to process paper rather than electronic claims. Paper claims are considerably costlier to process.

In general, CO-OPs were substantially disadvantaged when compared to commercial competitors, and these disadvantages, created by the ACA, were substantial factors in bringing about the failure of the Federal CO-OP Program, including the failure of NHC.

6.6 The ACA's 3 Rs Failed to Protect CO-OPs from Huge Losses

The ACA established a risk management/premium stabilization program often referred to as the "3 Rs." The 3Rs consist of "a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program to provide payments to health insurance issuers that cover higher-risk populations and to more evenly spread the financial risk borne by issuers."[81] The premium stabilization program led CO-OPs to price their policies more aggressively.[82] Aggressive pricing was needed because CO-OPs had to compete on Health Insurance Exchanges with more established commercial insurers.[83] In its article on NHC's closure, Modern Healthcare reported:

> "The closure in Nevada also reinforces how difficult it is for new insurers to enter a marketplace that is dominated by large carriers with noticeable brands and footprints, such as local Blue Cross and Blue Shield plans and national giants like Aetna and Anthem."[84]

Most CO-OPs (including NHC) counted on the premium stabilization program to provide a financial cushion if their pricing turned out to be too aggressive.[85] Specifically, the purpose of the risk corridor program was to "protect against uncertainty in rate setting for qualified health plans by limiting the extent of issuers' financial losses and gains."[86] After CO-OP premium pricing decisions had already been

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[81] Department of Health and Human Services. "45 CFR Parts 153, 155, 156, 157, and 158: Patient Protection and Affordable Act; HHS Notice of Benefit and Payment Parameter for 2014". Federal Register, Vol. 78, No. 47, dated March 11, 2013, p. 15411. Available at https://www.govinfo.gov/content/pkg/FR-2013-03-11/pdf/2013-04902.pdf.

[82] Department of Health and Human Services. "45 CFR Part 153: Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment". Federal Register, Vol. 77, No. 57, effective on March 23, 2012. Available at https://www.govinfo.gov/content/pkg/FR-2012-03-23/pdf/2012-6594.pdf.

[83] James, J., "The CO-OP Health Insurance Program". Health Affairs Health Policy Brief, dated February 28, 2013. DOI: 10.1377/hpb20130228.47227, p. 1. Available at https://www.healthaffairs.org/do/10.1377/hpb20130228.47227/full/. See also GAO. "Private Health Insurance: Premiums and Enrollment for New Nonprofit Health Insurance Issuers Varied Significantly in 2014". Report to Congressional Requesters, dated April 2015. GAO-15-304, p. 21. Available at http://www.gao.gov/assets/670/669945.pdf.

[84] Herman, B. "With Nevada co-op closing, are more to come?" Modern Healthcare, dated August 27, 2015. Available at https://www.modernhealthcare.com/article/20150827/NEWS/150829888/with-nevada-co-op-closing-are-more-to-come.

[85] Goodell, S."Risk Corridors (Updated)." Health Affairs Health Policy Brief, updated on February 19, 2015. DOI: 10.1377/hpb201502019.938066, p. 2. Available at https://www.healthaffairs.org/do/10.1377/hpb20150219.938066/full/healthpolicybrief_134.pdf.

[86] Department of Health and Human Services. "45 CFR Parts 153, 155, 156, 157 and 158: Patient Protection and Affordable Act; HHS Notice of Benefit and Payment Parameter for 2014". Federal Register, Vol. 78, No. 47, dated

made, stabilization payments were reduced to the CO-OPs by subsequent budget changes by Congress and payments were significantly lower than expected. As previously noted, in 2014, CO-OPs received only 12.6 percent of the risk corridor payments they expected to receive (and should have been received, based on the United States Supreme Court's decision in *Maine Community Health Options v. United States*).[87] In addition, payments were substantially delayed.[88] As a result, the vast majority of CO-OPs experienced financial shortfalls that they could not overcome. In its amicus brief to the United States Supreme Court in the *Moda* case, the National Association of Insurance Commissioners (NAIC) argued that, "as to the risk corridor program, the government has not been a fair or reliable partner. Through the ACA, the government induced insurers into the health insurance market only to directly compromise these companies' financial condition once they committed."[89] The Supreme Court agreed with NAIC and concluded that:

> "In establishing the temporary Risk Corridors program, Congress created a rare money-mandating obligation requiring the Federal Government to make payments under §1342's formula...These holdings reflect a principle as old as the Nation itself: The Government should honor its obligations. Soon after ratification, Alexander Hamilton stressed this insight as a cornerstone of fiscal policy."[90]

Further, under the permanent risk adjustment program, many CO-OPs owed money, while large established health plans received payments.[91] The risk adjustment program transfers funds from plans with healthier enrollees to plans with less healthy enrollees to avoid adverse selection. As discussed, for the 2014 benefit year, the CO-OPs did not meet enrollment projections and had claims and/or administrative expenses that exceeded premiums. A report by The American Academy of Actuaries concluded that, "If an insurer has low premiums due to incorrectly anticipating the total market and then attracted a healthier-than-average membership resulting in a risk adjustment transfer payment, there may not be sufficient premiums to cover the transfer payment. If an insurer does not have

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on March 11, 2013 Page 15411. Available at https://www.govinfo.gov/content/pkg/FR-2013-03-11/pdf/2013-04902.pdf.

[87] CCIIO. "Risk Corridors Payment Proration Rate for 2014". CMS, dated October 1, 2015. Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf.

[88] Corlette, S.; Miskell, S.; Lerche, J.; and Giovannelli, J. "Why Are Many CO-Ops Failing? How New Nonprofit Health Plans Have Responded to Market Competition". The Commonwealth Fund, dated December 2015, p. 8. Available at https://www.commonwealthfund.org/publications/fund-reports/2015/dec/why-are-many-co-ops-failing-how-new-nonprofit-health-plans-have.

[89] Supreme Court of the United States. "Brief for the National Association of Insurance Commissioners as Amicus Curiae in Support of Petitioners" for the matter of Moda Health Plan, Inc. et al., v. United States, dated September 6, 2019. Available at https://www.supremecourt.gov/DocketPDF/18/18-1023/114975/20190906134843972_18-1023_18-1028_18-1038tsacNationalAssociationOfInsuranceCommissioners.pdf.

[90] Supreme Court of the United States. Maine Community Health Options v. United States, 590 U. S._____(2020), Nos. 18-1023, 18-1028, 18-1038, p. 30.

[91] CCIIO. "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year". CMS, revised on September 17, 2015. Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf.

sufficient premiums to cover its claims and administrative expenses, the shortfall could result in solvency problems unless the insurer has adequate surplus or access to additional funds from external sources."[92] In my opinion, it is highly unlikely that any health insurers would have entered into the ACA market absent the establishment of the 3Rs program.

6.7 The Health Exchanges Were Plagued by Technical Issues

Technical issues with the health exchanges during the initial enrollment period contributed to lower enrollment, inaccurate application data, and increased administrative costs for many CO-OPs. The ACA "requires the establishment of a health insurance marketplace in each state and the District of Columbia to assist individuals and small businesses in comparing, selecting, and enrolling in health plans offered by participating private issuers of qualified health plans."[93] States could establish their own marketplace or use the federally facilitated marketplace, (Healthcare.gov), which was created by CMS for states not establishing their own.[94] The online marketplaces, also called exchanges, are where consumers shop for ACA plans and submit enrollment information. The exchange system is responsible for making eligibility determinations, applying subsidies, facilitating data exchange with the individual health plans, and in some instances collecting and transmitting premiums. In 2014, 36 states used the federally facilitated marketplace and the other 14 states and Washington, D.C. launched their own marketplaces.[95, 96] The ACA required marketplaces to be operational by January 1, 2014.[97] The launch of Healthcare.gov and the state marketplaces for the first open enrollment period suffered from several technical issues, including both front-end and back-end issues.[98] Front-end problems consisted of website outages, delays and error messages.[99] Back-end issues impacted the transfer of information from the exchanges to the insurance carriers resulting in insurance companies either missing or receiving "incorrect, incomplete or

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[92] American Academy of Actuaries. "Insights on the ACA Risk Adjustment Program". A Public Policy Issue Paper, dated April 2016, p. 11. Available at https://www.actuary.org/sites/default/files/files/imce/Insights_on_the_ACA_Risk_Adjustment_Program.pdf.

[93] GAO. "CMS Has Taken Steps to Address Problems, but Needs to Further Implement System Development Best Practices". Report to Congressional Requesters, dated March 2015. GAO-15-238, p. 1. Available at https://www.gao.gov/assets/670/668834.pdf.

[94] GAO. "CMS Has Taken Steps to Address Problems, but Needs to Further Implement System Development Best Practices". Report to Congressional Requesters, dated March 2015. GAO-15-238, pp. 3-4. Available at https://www.gao.gov/assets/670/668834.pdf.

[95] OIG. "Challenge 1: Implementing, Operating, and Overseeing the Health Insurance Marketplaces. Available at https://oig.hhs.gov/reports-and-publications/top-challenges/2014/challenge01.asp.

[96] Vestal, C. and Ollove, M. "Why Some State Health Exchanges Worked". Kaiser Health News, dated December 11, 2013. Available at https://khn.org/news/why-some-state-run-health-exchanges-worked/.

[97] 111th Congress. "Patient Protection and Affordable Care Act". Public Law 111–148, dated March 23, 2010. Section 1321(c).

[98] Levinson, D. R. "HealthCare.gov: CMS Management of the Federal Marketplace, A Case Study". Department of Health and Human Services: Office of Inspector General, dated February 2016. OEI-06-14-00350, pp. i & ii. Available at https://oig.hhs.gov/oei/reports/oei-06-14-00350.pdf. See also Ornstein, C. "Epic Fail: Where Four See State Health Exchanges Went Wrong." ProPublica, dated February 6, 2014. Available at https://www.propublica.org/article/epic-fail-where-four-state-health-exchanges-went-wrong.

[99] GAO. "CMS Has Taken Steps to Address Problems, But Needs to Further Implement System Development Best Practices". Report to Congressional Requesters, dated March 2015. GAO-15-238, p. 13. Available at https://www.gao.gov/assets/670/668834.pdf. See also Exhibit 1.

duplicate" application files.[100] The HHS OIG cited marketplace technical difficulties as one reason why CO-OPs experienced lower-than-projected enrollment for 2014. These technical problems that affected the exchanges caused the CBO to reduce their 2014 estimate of enrollment by 1 million people.[101]

6.8 Commercial Insurers' Exchange Products Struggled Financially

Not only did CO-OPs experience difficulties when ACA policies were first made available in 2014, commercial insurers experienced similar problems. National commercial insurers are now less commonly found on the exchanges. In 2013, 70 percent of the issuers in the individual markets were limited coverage specialists and large national commercial carriers; by 2017 they comprised about only 30 percent of issuers.[102] Large losses due to lower-than-anticipated enrollments and sicker enrollees were cited as the main reason for withdrawal from the state exchanges.[103] Between 2014 and 2016, Aetna lost nearly $700 million in its individual exchange business line and completely exited the exchanges in 2018.[104] Humana lost money on its individual exchange business as well. "In late 2015 the company [Humana] set aside $176 million in reserves to cover losses on the individual business;"[105]Humana pulled out of the ACA exchanges for 2018.[106] UnitedHealth lost $475 million in 2015 and anticipated losing $650 million in 2016 on its marketplace business, resulting in mostly exiting the health insurance exchanges in 2017.[107] An article by The Washington Post, quoting Katherine Hempstead, who directs the Robert Wood Johnson Foundation's work on health insurance, said of UnitedHealth,

> "They're the largest carrier. They're very good at looking at their own data, 'If they can't make this work, that means this is a really tough environment.'"[108]

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[100] Cheney, K. and Millman, J., "State exchanges hit data snags." Politico, dated December 6, 2013. Available at https://www.politico.com/story/2013/12/obamacare-state-exchanges-technical-glitches-100757.
[101] CBO. "Appendix B: Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act". The Budget and Economic Outlook: 2014 to 2024, dated February 2014. Page 112. Available at https://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixB.pdf.
[102] Hempstead, K. "A Big Picture Look at the Individual Market, 2013-2017". Robert Wood Johnson Foundation, dated June 6, 2017. Available at https://www.rwjf.org/content/rwjf/en/library/research/2017/05/a-big-picture-look-at-the-individual-market.html.
[103] Reuters. "Cigna joins health insurance industry pullback from Obamacare". St. Louis Post-Dispatch, dated November 4, 2016. Available at https://www.stltoday.com/business/local/cigna-joins-health-insurance-industry-pullback-from-obamacare/article_5903d9ad-7131-5da4-a7e3-c62a3184ef4e.html.
[104] Luhby, T. "Aetna to Obamacare: We're outta here". CNN Business, dated May 10, 2017. Available at https://money.cnn.com/2017/05/10/news/economy/aetna-obamacare/.
[105] Reuters Staff. "Humana may exit Obamacare individual plans in some states". Reuters, dated May 4, 2016. Available at https://www.reuters.com/article/us-humana-results-idUSKCN0XV1BH.
[106] Luhby, T. "Humana pulls out of Obamacare for 2018". CNN Business, dated February 14, 2017. Available at https://money.cnn.com/2017/02/14/news/economy/humana-obamacare-insurer/.
[107] Galewitz, P. "United Healthcare to Exit All but 'Handful' Of Obamacare Markets in 2017". Kaiser Health News, dated April 19, 2016. Available at https://khn.org/news/unitedhealthcare-to-exit-all-but-handful-of-obamacare-markets-in-2017/.
[108] Goldstein, A. and Johnson, C. Y. "UnitedHealth Group says it is scaling back efforts in ACA exchanges". The Washington Post, dated on November 19, 2015. Available at https://www.washingtonpost.com/national/health-

The large national insurance carriers' exchange business was small in comparison to their employer sponsored and Medicare Advantage business, allowing them to absorb large losses unlike the CO-OPs. The distribution of individual and group coverage for all commercial insurers for relevant years is shown in Table 1.[109]

Table 1
Distribution of Commercial Group and Individual Health Coverage

Type of Coverage	2012	2013	2014	2015
United States:				
Individual Coverage	9.26%	9.43%	10.91%	12.50%
Group Coverage	90.74%	90.57%	89.09%	87.50%
Nevada:				
Individual Coverage	9.62%	7.55%	9.26%	12.73%
Group Coverage	90.38%	92.45%	90.74%	87.27%

Prior to the implementation of the ACA, approximately 90 percent of commercial health insurers' business was in group coverage. Individual coverage represented only approximately 10 percent. Even after the implementation of the ACA, individual coverage only accounted for 15 percent of all commercial health coverage. Although commercial insurers suffered losses in the early years of the implementation of the ACA, these losses had a limited impact on their overall profitability. The vast majority of CO-OP coverage was for individuals and they had no other business to offset their losses.

In my opinion, the problems experienced by commercial insurers, as well as CO-OPs, makes it undeniably clear that it was very difficult for any entity (including NHC) to accurately predict enrollment and claims volume for the new products offered on the exchanges.

6.9 Nineteen of the 23 CO-OPs Failed

The reasons cited above for the failure of the Federal CO-OP Program caused 19 of 23 CO-OPs (including NHC) to cease operations as of the date of this report. In addition, on August 11, 2020, the New Mexico CO-OP announced that it would cease operations as of December 31, 2020.[110] Table 2 identifies the CO-OPs that failed (in the order of the date that they ceased operations) as well as the reasons cited for their individual failures:

science/unitedhealthcare-says-it-is-scaling-back-efforts-in-aca-exchanges/2015/11/19/5c45d9e0-8ee2-11e5-baf4-bdf37355da0c_story.html.

[109] Kaiser Family Foundation. "Health Insurance Coverage of the Total Population". State Health Facts Data. Available at https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[110] New Mexico Health Connections. "New Mexico Health Connections, Non-Profit Health Insurer, to Cease Operations in 2021". PRNewswire, dated August 11, 2020. https://www.prnewswire.com/news-releases/new-mexico-health-connections-non-profit-health-insurer-to-cease-operations-in-2021-301110358.html.

Table 2[111]
Health Insurance CO-OPs That Failed

State	CO-OP	Date Ceased Operations	Higher Than Expected Claims Costs	Lower than Expected Premium Revenue	Limited Capital/ Insolvency	Federal Risk Adjustment Higher/Lower than Expected	Exchange Technical Issues
Iowa/Nebraska	Midwest Members Health	2/28/2015	√	√	√	√	√
New York	Freelancers Health Service Corporation	9/25/2015		√	√	√	
Tennessee	Community Health Alliance Mutual Insurance Company	10/14/2015		√	√		√
Colorado	Colorado Health Insurance Cooperative	10/16/2015			√	√	
South Carolina	Consumers Choice Health Insurance Company	10/22/2015			√	√	√
Utah	Arches Community Health Care	10/27/2015			√	√	√

[111] Primary source for information in Table 2 is U.S. Health Policy Gateway. Available at http://ushealthpolicygateway.com/vii-key-policy-issues-regulation-and-reform/patient-protection-and-affordable-care-act-ppaca/ppaca-repeal/components-of-aca-not-working-well/components-of-aca-not-working-well-health-exchanges/nonprofit-consumer-operated-and-orinted-plan-organizations-co-os/impact-by-state/. See also Exhibit 2.

State	CO-OP	Date Ceased Operations	Higher Than Expected Claims Costs	Lower than Expected Premium Revenue	Limited Capital/ Insolvency	Federal Risk Adjustment Higher/Lower than Expected	Exchange Technical Issues
Arizona	Compass Cooperative Health Network d/b/a Meritus Health Partners Service	10/30/2015		√	√		√
Michigan	Michigan Consumers Healthcare CO-OP	11/3/2015	√	√	√	√	√
Kentucky	Kentucky Health Care Cooperative	12/31/2015	√		√	√	
Louisiana	Louisiana Health Cooperative	12/31/2015			√		√
Nevada	Nevada Health Cooperative	12/31/2015	√	√	√	√	√
Oregon	Freelancers CO-OP of Oregon d/b/a Health Republic Insurance of Oregon	12/31/2015	√		√	√	√
Ohio	Coordinated Health Plans of Ohio	5/26/2016			√		√

State	CO-OP	Date Ceased Operations	Higher Than Expected Claims Costs	Lower than Expected Premium Revenue	Limited Capital/ Insolvency	Federal Risk Adjustment Higher/Lower than Expected	Exchange Technical Issues
Oregon	Oregon's Health CO-OP (formerly Community Care of Oregon)	7/11/2016	√		√	√	√
Illinois	Land of Lincoln Health	7/14/2016			√	√	√
New Jersey	Freelancers CO-OP of New Jersey	9/12/2016			√	√	√
Connecticut	Healthy - CT	11/1/2016			√	√	
Massachusetts	Minuteman Health	6/23/2017		√	√	√	√
Maryland	Evergreen Health Cooperative	7/31/2017			√	√	√
	Count		6	7	19	15	15
	Percent of Total (Count/19)		32%	37%	100%	79%	79%

As of the date of this report, four CO-OPs are still operating; namely:

New Mexico Health Connections. Although it is currently operating, New Mexico Health Connections announced that it will cease operations on December 31, 2020, citing continuing high claims costs and the absence of opportunities for investment.[112] Previously, it experienced serious financial problems through 2017[113] as it incurred $40 million in losses from 2014 through 2016 and an additional $10 million loss in 2017.[114,115] The CO-OP also faced difficulties because of its inability to meet the requirements of the Federal government's risk adjustment program; the Federal government indicated that the CO-OP owed $8.9 million for 2017.[116] In 2017, the CO-OP's entire Board of Directors resigned in an effort to get the State's Superintendent of Insurance to take control of what the Directors described as an insolvent organization.[117] Rather than taking control of the CO-OP, the Superintendent approved the sale of the CO-OP's commercial business to Evolent Health, a for-profit health insurer, for more than $10 million.[118]

Maine Community Health Options. It was the only CO-OP that recorded a profit in 2014, but it experienced substantial losses in 2015 and 2016.[119] Losses for 2015 totaled $74 million including operating losses of $31 million and a premium deficiency reserve of $43 million for 2016. Early in 2016, the Maine Bureau of Insurance asked the CO-OP to stop selling underpriced plans. By the end of the year, the CO-OP ceased selling individual coverage and enrollment was frozen. In 2016, the CO-OP closed its operations in New Hampshire.[120] In addition, the Bureau of Insurance initiated a

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[112] New Mexico Health Connections. "New Mexico Health Connections, Non-Profit Health Insurer, to Cease Operations in 2021". PRNewswire, dated August 11, 2020. https://www.prnewswire.com/news-releases/new-mexico-health-connections-non-profit-health-insurer-to-cease-operations-in-2021-301110358.html.
[113] Baca, M. C., "Health Connections board sought state control". Albuquerque Journal, dated January 9, 2018. Available at https://www.abqjournal.com/1117076/health-connections-board-resigned.html.
[114] Baca, M. C., "Health Connections board sought state control". Albuquerque Journal, dated January 9, 2018. Available at https://www.abqjournal.com/1117076/health-connections-board-resigned.html.
[115] Jarmon, G. L. "CMS Oversight Must Continue Because All Remaining Consumer Operated and Oriented Plans Were Not Profitable and May Not be Viable and Sustainable". Department of Health and Human Services: Office of Inspector General, dated August 2017. A-005-16-00027. Table 3.
[116] New Mexico Health Connections. "NM lawsuit central to 'Obamacare' change". In the News, dated July 9, 2018. Available at https://mynmhc.org/In_the_News.aspx?c74293735b5a4721b9c160aa3438c41bblogPostId=17a637592ae04c2f8996f9c26835ec33.
[117] Baca, M. C. "Health Connections board sought state control". Albuquerque Journal, dated on January 9, 2018. Available at https://www.abqjournal.com/1117076/health-connections-board-resigned.html.
[118] New Mexico Health Connections. "Evolent Health Completes Acquisition of Assets from New Mexico Health Connections". In the News, dated January 2, 2018. Available at https://www.mynmhc.org/In_the_News.aspx?c74293735b5a4721b9c160aa3438c41bblogPostId=0e567dc28d934196a890ec11a49731b0#BlogContent.
[119] Jarmon, G. L. "CMS Oversight Must Continue Because All Remaining Consumer Operated and Oriented Plans Were Not Profitable and may not be Viable and Sustainable". Department of Health and Human Services: Office of Inspector General, dated August 2017. A-005-16-00027. Table 3.
[120] New Hampshire Insurance Department. "Maine-Based Health Insurance Co-op to Withdraw from NH in 2017". Press Release, dated on September 1, 2016. Available at https://www.nh.gov/insurance/media/pr/2016/documents/090116.pdf

plan to put the CO-OP in receivership. The plan, which included termination of up to 20 percent of the CO-OP's policies, was rejected by CMS.[121]

Montana Health Cooperative. It continues to provide coverage[122] although it experienced substantial losses in its first two years (it also provides coverage in Idaho). It lost $6 million in 2014 and more than $40 million in 2015.[123] Worries that the CO-OP was overextending its resources and heading towards insolvency led it to discontinue offering coverage during the first six months of 2017.[124] In 2019, Matt Rosendale, the Montana State Auditor who oversaw the state's health insurance market, remarked that he believed that the CO-OP would remain in operation but doubted that it would be able to repay the loans it received from the Federal government.[125]

Common Ground Healthcare Cooperative (Wisconsin). It incurred more than $84 million in losses by the end of 2015 and continued to incur losses in 2016 and 2017.[126,127] In 2016, the CO-OP made a substantial change in its provider network, moving from a broad network to contracting with just two health systems. This change allowed the CO-OP to cut costs. At the same time, it increased premiums which led to its generation of operating profits in 2018.

In my opinion, it is obvious that the failure of nearly all of the Federally funded CO-OPs was due in part to claims costs greatly exceeding expectations and capital limitations that were inherent in the ACA. Most start-up businesses experience losses in their initial years of operation. Start-ups that succeed typically have financial resources that allow them to survive their early years. Not only did the CO-OPs have limited financial resources as they started operations, they did not even receive the resources that they were told they would receive from the Federal government. When the Federal government's risk corridor program was funded with only 12.6 percent of the funds promised to them and which they expected to have, most CO-OPs' insolvency and failure was virtually guaranteed.

[121] Norris, L. "Maine health insurance marketplace: history and news of the state's exchange". healthinsurance.org, dated September 1, 2020. Available at https://www.healthinsurance.org/maine-state-health-insurance-exchange/.
[122] Mountain Health CO-OP. Available at https://www.mountainhealth.coop/.
[123] Jarmon, G. L. CMS Oversight Must Continue Because All Remaining Consumer Operated and Oriented Plans Were Not Profitable and may not be Viable and Sustainable". Department of Health and Human Services: Office of Inspector General, dated on August 2017. A-005-16-00027. Table 3.
[124] Calvan, B. C. "Montana's Health Co-op Remains Standing As Others Falter". Montana Publica Radio, dated on August 14, 2017. Available at https://www.mtpr.org/post/montanas-health-co-op-remains-standing-others-falter.
[125] Calvan, B. C. "Montana's Health Co-op Remains Standing As Others Falter". Montana Publica Radio, dated on August 14, 2017. Available at https://www.mtpr.org/post/montanas-health-co-op-remains-standing-others-falter.
[126] Jarmon, G. L. "CMS Oversight Must Continue Because All Remaining Consumer Operated and Oriented Plans Were Not Profitable and may not be Viable and Sustainable". Department of Health and Human Services: Office of Inspector General, dated on August 2017. A-005-16-00027. Table 3.
[127] Boulton, G. "Common Ground Healthcare Cooperative faces a few fateful months". Journal Sentinel, dated July 18, 2016. Available at http://archive.jsonline.com/business/common-ground-healthcare-cooperative-faces-a-few-fateful-months-b99761764z1-387365621.html.

7. NHC Failed for Similar Reasons as the Other CO-OPs

Plaintiff's experts completely ignore the failure of the Federal CO-OP Program and instead attribute NHC's failure to UHH and NHS (and the other defendants in the Case). None of the other CO-OPs used UHH and NHS, and yet 18 of them (out of 23) failed during the same general time period, and the remaining CO-OPs struggled financially (one of which is closing at the end of 2020). In my opinion, NHC failed due to the failure of the Federal CO-OP Program, and not because of UHH's and/or NHS's performance. Further, and most importantly, nothing UHH or NHS did or failed to do caused or was a substantial factor in bringing about NHC's failure; in other words, NHC would have failed irrespective of how well its vendors (like UHH and NHS) performed.

When NHC announced it was winding down, NHC's Chief Executive Officer (Pam Egan) stated, "With a second year of high claims costs and limited opportunities for new investment, it has become clear that the amount of growth required to provide quality care at reasonable rates will be unlikely in the next plan year."[128] NHC's Receiver – the Commissioner of the Nevada Department of Insurance – publicly cited the following three main reasons as causing NHC to be financially unsound:

- "The CO-OP's operating loss in the most previous 6-month period, is greater than 50 percent of the insurer's surplus which is in excess of the statutory minimum surplus required for HMOs pursuant to Nevada Administrative Code ("NAC") 695C.130.
- Upon expiration of the permitted practice, the CO-OP's capital & surplus will likely show that it is below the statutory minimum requirement pursuant to NAC 695C.130.
- The CO-OP does not have access to additional sources of capital to improve its financial outlook."[129]

The Receiver provided additional evidence that supported the conclusion that NHC was in an unsound condition, summarized as follows:

- "The CO-OP's claims unpaid reserve has increased significantly over the first six months of 2015.
- Continued losses over the first six months of 2015 resulted in the immediate recognition of a large premium deficiency reserve as of June 30, 2015.
- The collectability of the CO-OP's accounts receivable from the Federal Risk Corridor program in the amount of $16,200,240 as of June 30, 2015, is uncertain."[130]

[128] Insurance Business. "Breaking News: Thousands left without coverage as ACA co-op goes out of business". Insurance Business America, dated on August 26, 2015. Available at https://www.insurancebusinessmag.com/us/news/breaking-news/breaking-news-thousands-left-without-coverage-as-aca-coop-goes-out-of-business-24183.aspx.
[129] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP (September 25, 2015). Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01039979.
[130] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP (September 25, 2015). Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01039979.

The Receiver's Insurance Examiner stated, "Due to the significant losses experienced since its inception, along with the lack of new sources of capital, the CO-OP is unsound pursuant to NRS 696B.210(2)."[131] And the Receiver's Lead Actuary stated, "Due to the size of the liabilities in relation to assets, the inadequacy of premiums to support incurred claims and expenses, and the uncertainty surrounding the collectability of large receivables, the CO-OP is unsound pursuant to NRS 696B.210(2)."[132]

Importantly, public announcements by NHC and the Receiver make no mention of UHH and/or NHS as the cause or substantial factor in bringing about NHC's failure.

7.1 NHC Claims Costs Exceeded Premium Revenue

NHC experienced significantly higher than expected claims costs in plan years 2014 and 2015. In 2014, a forecast prepared by Basil Dibsie (NHC's Chief Financial Officer) and presented to the NHC Board of Directors in February 2014, budgeted $38 million in member claims costs for the plan year 2014.[133] However, NHC's member claims costs were $57 million for the plan year 2014[134], which is 48 percent more than forecasted. For the plan year 2015, $88 million was budgeted for claims costs for NHC's members, according to a forecast prepared by Milliman.[135] Similar to 2014, NHC experienced significantly higher than expected medical costs for its members in 2015 (i.e., $111 million[136]), $24 million more than budgeted (or 27 percent higher). Not only were claims costs significantly higher than budgeted, but premium revenue also failed to meet expectations. These data are presented in Table 3 below.

[131] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP (September 25, 2015). Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01039985-01939988.
[132] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP (September 25, 2015). Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01040007-1040010.
[133] 2014 NHC Budget/Forecast Presented to NHC BOD, dated February 14, 2014. PLAINTIFF00564202.xlsx.
[134] Javelina SDR Backup. PLAINTIFF02484563. Actual total medical costs in 2014 and 2015 calculated by *Dateincurred* in *AdjudicationResult* table. NHC's capitation rates were also more than forecasted, Milliman calculated PMPM at $73 while WellHealth was at $92.50 PMPM. See NHC Board of Directors Minutes for May 23, 2014. LARSON014384-LARSON014390.
[135] 2015 NHC Budget/Forecast in NHC Internal Pro Forma Prepared by Milliman. PLAINTIFF00501321.xlsm.
[136] Javelina SDR Backup. PLAINTIFF02484563. Actual Total Medical Costs in 2014 and 2015 Calculated by *Dateincurred* in *AdjudicationResult* table. Actual medical costs are exclusive of capitation payments, rebates, and reinsurance payments/recoveries. See also, "…particularly given NHC's 2014 BCR as reported in its NAIC annual statement filing before reinsurance recoveries was 102%." Fish II Report, p. 16. See also, "For the year ended December 31, 2014, NHC reported net premium income of $55.5 million which was not even sufficient to cover hospital and medical benefits incurred of $57.5 million, excluding reinsurance." DeVito Report, p. 20.

Table 3
CO-OP Budgeted vs. Actual Claims Costs in 2014 and 2015

	2014			2015		
	Forecast	Actual	Pct. Diff.	Forecast	Actual	Pct. Diff.
Membership	175,152	162,632	-7.1%	307,982	170,252	-44.7%
Premium Revenue ($)	49,774,325	51,526,023	3.5%	97,545,851	83,166,546	-14.7%
Total Claims Costs ($)	38,281,138	56,715,824	48.2%	87,541,855	111,376,195	27.2%

Increased claims costs incurred by NHC in plan years 2014 and 2015 were not due to an unexpectedly high number of members. In fact, NHC failed to meet its budgeted enrollment figures in both years. In 2014, NHC forecasted a total of 175,172 member-months,[137] but only enrolled members for a total of 162,632 member-months,[138] missing expectations by 7 percent. For the plan year 2015, NHC missed its enrollment expectations by 45 percent, with 307,982 member- months budgeted,[139] but only 170,252 experienced.[140] The Receiver noted that "continued losses over the first six months of 2015 resulted in the immediate recognition of a large premium deficiency reserve as of June 30, 2015."[141]

Higher than expected claims costs experienced by NHC were due to several factors unique to members enrolled in ACA policies, especially the enrollment of sicker than expected members. There is no evidence that higher claims costs were due to the actions of UHH and/or NHS. NHC's claims cost experience was similar to the claims cost experience of all insurers that entered the ACA individual market.

I already noted that it was difficult for CO-OPs, including NHC, to estimate claims cost based on past experience (since there was no past experience), especially for the costs of members with preexisting conditions. Little information was available to project how claims costs would change once the ACA was implemented.

[137] Member months: total number of individuals enrolled times the total number of months enrolled. See 2014 NHC Budget/Forecast Presented to NHC BOD, dated February 14, 2014. PLAINTIFF00564202.
[138] 2014 Annual Statement of the Nevada Health CO-OP to the Insurance Department of the State of Nevada. PLAINTIFF01461315-01461404.
[139] 2015 NHC Budget/Forecast in NHC Internal Pro Forma Prepared by Milliman. PLAINTIFF00501321.xlsm.
[140] Nevada Health Co-Op Income Statement for the Period from January 1, 2015 to December 31, 2015 As of July 18, 2017. PLANTIFF02499092.
[141] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP. Filed September 25, 2015. Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01039979.

The following two analyses describe the difference between NHC's expectations of claims costs and its actual experience. First, the expected distribution of claims costs among types of care for 2014 were identified in rate submissions to the Nevada Department of Insurance.[142] The actual distribution of claims costs was calculated using Javelina data.[143] Table 4 presents this data.

Table 4
Expected and Actual Distribution of Claims Costs - 2014[144]

Type of Claims Cost	Expected Distribution	Percent	Actual Distribution	Percent
Inpatient Hospital	$9,188,416	23.00%	$16,110,222	28.41%
Outpatient Hospital	$10,826,351	27.10%	$9,112,009	16.07%
Professional	$11,066,049	27.70%	$19,015,003	33.53%
Medications (Rx)	$8,069,827	20.20%	$12,478,588	22.00%
Other	$798,993	2.00%	$0	0.00%
Total	**$39,949,636**	**100%**	**$56,715,824**	**100%**

It is most notable that in 2014, inpatient hospital claims costs on a dollar basis were 75.3 percent higher than expected and professional claims costs on a dollar basis were 71.8 percent higher than expected. In comparison, overall claims costs on a dollar basis for 2014 were 41.9 percent higher than expected. In my opinion, the higher levels of inpatient hospital costs and professional costs were primarily due to the enrollment of sicker people than expected.

NHC's enrollment of sicker people is borne out in the second analysis, which is presented in Table 5, below. As previously noted, the enrollment of people with preexisting conditions was significantly changed with the implementation of the ACA. Previously, people with preexisting conditions did not have access to health coverage and, as a result, there was a pent-up demand for coverage. To determine the impact of this increased demand, I used Javelina data to identify claims for NHC members with preexisting conditions who enrolled in 2014, when coverage became available to them. I used

[142] Data Collection Template. PLAINTIFF00914461.xlsm.
[143] UHH Javelina SDR Backup File. PLAINTIFF02484563.
[144] Expected distribution: Expected Distribution was calculated from PLAINTIFF00914461. Claims for Inpatient Hospital, Outpatient Hospital, Professional, Medications (Rx) were calculated using Section II: Components of Premium Increase. For each product included in the analysis, cost of claims per member month for each type of claim were multiplied by the projected member months for that product. Percentage distribution of claims by type were calculated and applied to the total expected claims. Actual Distribution: The actual distribution was calculated using the *AdjudicationResult* table from the SDR's Javelina SQL backup (PLAINTIFF02484563) for claims incurred in 2014. The *FormType* and *InpatOutpat* fields were used to categorize claims. Claims costs were calculated using the *TotProvPaid* field for medical claims and using *TotCharge* minus *TotPatResp* for Rx claims. In addition to claims with *ClaimStatus* "PAID", claims with *ClaimStatus* "PAY" (not yet paid) are also included in these totals. Totals are not equal to the sum of the values due to rounding.

primary diagnosis codes to identify enrollees with preexisting conditions and included all of their claims (inpatient hospital, outpatient hospital, professional, medications and other).[145]

There is no universally accepted definition of a preexisting condition other than it is a condition that was present when a person sought to purchase health insurance, and which would have disqualified them for coverage prior to the ACA. For this reason, I selected only a sample of preexisting conditions, based on industry literature.[146] Several additional conditions could qualify as preexisting, which means that the list of conditions and the total claims costs attributed to them in Table 5 is likely higher than I calculated.

Table 5
Claims Cost Distribution for Preexisting Conditions – 2014[147]

Pre-Existing Condition	Claims Cost*	Percent of Total Claims Cost	Percent of Total Claims
Hypertension	$13,902,380	24.51%	12.58%
Cancer	$11,573,781	20.41%	7.12%
Diabetes	$9,502,422	16.75%	8.16%
Renal Disease	$5,901,314	10.41%	4.09%
Congestive Heart Failure	$5,200,711	9.17%	1.97%
Coronary Artery Disease	$4,791,827	8.45%	3.06%
HIV	$3,202,906	5.65%	0.92%
COPD	$3,107,306	5.48%	2.83%
Asthma	$2,127,048	3.75%	2.07%
Hepatitis	$1,850,444	3.26%	0.99%
Multiple Sclerosis	$1,251,985	2.21%	0.30%
Crohn's Disease/Ulcerative Colitis	$1,138,018	2.01%	0.80%
Maternity**	$1,014,676	1.79%	0.69%
Epilepsy	$805,651	1.42%	0.51%
Lupus	$398,380	0.70%	0.37%
Stroke	$197,920	0.35%	0.22%
Parkinson's Disease	$52,438	0.09%	0.07%
Cerebral Palsy	$29,260	0.05%	0.04%
Sum Total*	**$66,048,464**	**116.46%**	**46.79%**
Distinct Total*	**$37,473,872**	**66.07%**	**27.59%**

[145] See Exhibit 3.
[146] See https://www.kff.org/health-reform/issue-brief/pre-existing-condition-prevalence-for-individuals-and-families/, https://www.insubuy.com/visitor-medical-insurance-pre-existing-conditions/, and https://www.healthcare.gov/glossary/pre-existing-condition/.
[147] Calculated using the *AdjudicationResult* table from the SDR's Javelina SQL backup (PLAINTIFF02484563) for claims incurred in 2014. Claims costs were calculated using the *TotProvPaid* field. Claims costs were calculated using the *TotProvPaid* field for medical claims and using *TotCharge* minus *TotPatResp* for Rx claims. In addition to claims with *ClaimStatus* "PAID", claims with *ClaimStatus* "PAY" (not yet paid) are also included in these totals.

*Claims cost includes the total costs for enrollees who have the condition listed. Because some enrollees have multiple conditions, there is double counting of claims costs as listed for each condition. For this reason, the sum of the percent of total cost (Sum Total) exceeds 100 percent. The distinct total eliminates all double counting and counts only individual members and their claims cost regardless of their number or pre-existing conditions.
**Maternity costs include costs for members who were pregnant prior to January 1, 2014.

Enrollees with preexisting conditions accounted for 66.1 percent of NHC's total claims costs in 2014.[148] Some preexisting conditions are especially costly. Only 474 enrollees (3.7 percent of all enrollees with claims) had claims that identified a primary diagnosis of cancer, but these enrollees accounted for 20.4 percent of NHC claims costs. Only 92 enrollees (0.7 percent of all enrollees with claims) had a primary diagnosis of congestive heart failure, but these enrollees accounted for 9.2 percent of NHC claims cost. In my opinion, it is clear that higher than expected claims costs was one of the most significant contributing factors to the failure of NHC. This factor is not attributable to UHH and/or NHS.

7.2 NHC was Disadvantaged Compared to Its Commercial Competitors

NHC had a very short start-up period. NHC's solvency and startup loans closed on May 17, 2012[149] for a January 1, 2014 start date. Premium rate setting had to be completed quickly with little available data to project enrollment and costs likely to be incurred by members who would enroll. Prior to the 2014 enrollment, NHC had no actual claims experience to use for premium rate setting. A mature insurer is more likely to have data that can be used to both project enrollment and set premium rates. CO-OPs (including NHC) did not have access to such data. If they set premium rates too high, they would receive less enrollment which would mean that their capability to retain capital to pay back their start-up loan was limited. If they set premium rates too low, they would experience greater enrollment but face much higher risk that they would attract sicker members who would require higher claims payments. Mature insurers have both reserves to offset these potential problems and data that allow them to more accurately predict premium rates. NHC (as well as the other CO-OPs), however, were at a distinct disadvantage without the data that their commercial competitors had.[150]

NHC was facing substantial competition from established insurers and had to set premiums at the same or lower levels than their competitors in order to gain enrollment.[151] As a result, for 2014 enrollment,

[148] If an enrollee, identified by the *PatientID* field in the *AdjudicationResult* table of the SDR's Javelina SQL backup (PLAINTIFF02484563), was found to have at least one claim with a primary diagnosis code (*PrimaryICD*) associated with a preexisting condition then they are assumed to have the preexisting condition. I found that there was a total of 12,654 enrollees with claims in 2014.
[149] Loan Agreement between CMS and Hospitality Health, Ltd., closing date May 17, 2012. LARSON000782-000863. First Amendment to the Loan Agreement. PLAINTIFF00428776-00428779. Second Amendment to the Loan Agreement. PLAINTIFF00637180-00637187.
[150] Corlette, S.; Miskell, S.; Lerche, J.; and Giovannelli, J. "Why Are Many CO-OPs Failing? How New Nonprofit Health Plans Have Responded to Market Competition". The Commonwealth Fund, dated December 2015, p. 14. Available at https://www.commonwealthfund.org/publications/fund-reports/2015/dec/why-are-many-co-ops-failing-how-new-nonprofit-health-plans-have.
[151] Feasibility Study of Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MG002725-MGT002762.

NHC signed up the highest percentage of individuals on the exchange who did not have health coverage previously.[152]

Other issues also constrained NHC's operations as compared to commercial competitors. Like the other CO-OPs, NHC had limited access to external capital sources. NHC's primary funding sources were CMS start-up and solvency loans.[153] Importantly, NHC's Receiver publicly cited NHC's lack of "access to additional sources of capital to improve its financial outlook" as a reason for NHC's being "unsound."[154] Additionally, all of NHC's business was in the individual and small-group insurance markets,[155] excluding them from the profitable large employer market dominated by their commercial competitors.

As mentioned previously, ACA legislation prohibited CO-OPs from including any person with current health insurance experience on their boards.[156] Although the intent of the prohibition appeared to be encouragement of consumer participation in the CO-OPs, it created a limitation by excluding important expertise that could help support the CO-OPs' operations.

At its demise, NHC was unable to maintain Nevada's statutory minimum financial requirements let alone a surplus level of 500 percent RBC as required under its CMS loans.[157]

7.3 ACA's 3 R's Failed to Protect NHC From Huge Losses

NHC expected a significantly higher Federal risk corridor payment than it received. For 2014, NHC calculated a risk corridor receivable of $10.7 million.[158] As of June 30, 2015, NHC had a risk corridor

[152] The Nelson A. Rockefeller Institute of Government. "Nevada: Round 1 State-Level Field Network Study of the Implementation of the Affordable Care Act", dated March 2014. Page 7.
[153] NHC's sponsoring entity provided de minimums support. CHF invested in-kind supporting valued at $121,398; pledged private financial support in the amount to $575,000; and agreed to waive its network access fee of $1 PMPM at an estimated value of $488,688 per year for the first three years. See Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MTG003343 at 002711.
[154] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP (September 25, 2015). Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01039979.
[155] Department of Health and Human Services. "45 CFR Part 156: Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program". Federal Register, Vol. 76, No. 239, effective December 13, 2011. 45 CFR § 156.515(c)(1), p. 77413. Available at https://www.govinfo.gov/content/pkg/FR-2011-12-13/pdf/FR-2011-12-13.pdf. See also Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343.
[156] Department of Health and Human Services. "45 CFR Parts 153, 155, 156, et al." Federal Register, Vol. 76, No. 239. effective December 13, 2011. 45 CFR § 156.515(b)(2)(v); 45 CFR § 156.510(b)(1)(i); 45 CFR § 156.505, pp. 77412 & 77413. Available at https://www.govinfo.gov/content/pkg/FR-2011-12-13/pdf/2011.-
[157] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP (September 25, 2015). Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01039979.
[158] CCIIO." Risk Corridors Payment and Charge Amounts for Benefit Year 2014". CMS, dated on November 19, 2015. Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf.

receivable of $16.2 million.[159] In total, NHC had a risk corridor receivable of $43.0 million.[160]NHC's Receiver stated that "the collectability of the CO-OP's accounts receivable from the Federal Risk Corridor program [ ] is uncertain."[161] The continued uncertainty of the federal receivables led NHC to conclude that winding down was "a reasonable next step."[162] The Receiver and NHC were correct; not only was the federal receivable uncertain, it was untimely.[163] As discussed, days after the Receiver's petition was filed, "HHS announced that payment proration rate for 2014 will be approximately 12.6 percent."[164] The proration resulted in a payment to NHC in the amount of $1.4 million,[165] $9.3 million less than expected; in other words, based on the Federal government's promises, NHC expected to receive $10.7 million, but received only $1.4 million. Although the United States Supreme Court decided on April 27, 2020, that the Federal government must make additional risk corridor payments, it is unclear how that decision will affect NHC and other CO-OPs that are now out of business. In any case, the failure of the Federal government to have made timely risk corridor payments to NHC substantially contributed to its insolvency and its ultimate failure.

7.4 The Nevada State Health Insurance Exchange Was Plagued by Technical Issues

Like health insurance exchanges in many other states, Nevada's exchange, the Silver State Health Insurance Exchange (Exchange), was plagued by technical issues. The State of Nevada contracted with Xerox (specifically, Xerox State Healthcare, LLC) in 2012 to build its online marketplace, including software that was to accept online applications and payments from consumers.[166] Significant problems with the Silver State Health Insurance Exchange, and specifically with Xerox, led to Xerox's contract

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[159] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP (September 25, 2015). Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01039979.

[160] Declaration of Mark F. Bennett for the matter of Barbara D. Richardson v. The United States, dated September 9, 2020. Case 1:18-cv-01731-MHS. A1-142 at A14. See also Opposition to Motion to Dismiss, and Cross-Motion for Summary Judgement for the matter of Barbara D. Richardson v. The United States, dated September 9, 2020. Case 1:18-cv-01731-MHS, p. 6.

[161] Petition for Appointment of Commissioner as Receiver and Other Permanent Relief; Request for Temporary Injunction Pursuant to NRS 696B.270(1). State of Nevada, Ex Rel. v. Nevada Health CO-OP (September 25, 2015). Case No: A-15-725244-C. PLAINTIFF01039973-01040018 at 01039979.

[162] Email and Attachments from Pamela Egan to Board Members Regarding Releases, dated September 25, 2015. UHH0540765-0540767.

[163] "HHS will begin collection of risk corridors charges in November 2015, and will begin remitting risk corridors payments to issuers starting December 2015." See CCIIO. "Risk Corridors Payment and Charge Amounts for Benefit Year 2014". CMS, dated November 19, 2015. Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf.

[164] CCIIO. "Risk Corridors Payment and Charge Amounts for Benefit Year 2014". CMS, dated November 19, 2015. Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf.

[165] CCIIO. "Risk Corridors Payment and Charge Amounts for Benefit Year 2014". CMS, dated November 19, 2015. Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf.

[166] "Nevada, Xerox in private talks to settle $75 million health care contract out of court". Las Vegas Sun, dated October 1, 2014. Available at https://lasvegassun.com/news/2014/oct/01/nevada-xerox-private-talks-settle-75-million-healt/.

being terminated in May 2014, all of which is well documented both publicly[167] and in the record.[168] The state identified more than 1,500 defects in the system.[169] But, the State and Xerox apparently agreed to settle their differences out of court.[170] However, two class-action lawsuits were filed against Xerox and Nevada's health exchange on behalf of: (i) hundreds of consumers harmed by the system failures, and (ii) insurance brokers who were never compensated due to system failures.[171] Consumers reported that they paid for insurance through the Silver State Exchange but were not reported as covered,[172] and brokers reported that they never received compensation on commissions due to "glitch-ridden payment and billing software for the exchange."[173] These lawsuits were jointly settled for 5 million dollars.[174] Additionally, on June 5, 2020, NHC sued the Silver State Health Insurance Exchange in an effort to collect premium payments that allegedly were paid to the Exchange, but were never paid to NHC.[175] The Exchange's Answer to the lawsuit points to the technical issues with Xerox as its defense.[176]

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[167] The Associated Press. "Nevada dumps Xerox for health exchange". Reno Gazette Journal, dated May 20, 2014. Available at https://www.rgj.com/story/money/business/2014/05/20/nevada-health-board-dumps-xerox-insurance-exchange/2285756/. See also Roerink, K., "Nevada fires Xerox, will join federal health care exchange". Las Vegas Sun, dated May 20, 2014. Available at https://lasvegassun.com/news/2014/may/20/nevada-fires-xerox-will-join-federal-health-care-e/. See also Chereb, S., "Report: No quick fix for Nevada health exchange". Las Vegas Sun, dated April 29, 2014. Available at https://lasvegassun.com/news/2014/apr/29/report-no-quick-fix-nevada-health-exchange/.

[168] NHC Board of Directors Minutes for October 16, 2013. LARSON000689-LARSON000692 at LARSON000690; NHC Board of Directors Minutes for November 20, 2013. LARSON000693-LARSON000696 at LARSON000695.; NHC Board of Directors Minutes for January 22, 2014. LARSON014362-LARSON014366 at LARSON014364.; NHC Board of Directors Minutes for February 19, 2014. LARSON014367-LARSON014370 at LARSON014368. See also, PLAINTIFF001131000-001131003: Xerox data was hugely problematic related to 2014 3Rs submission; and PLAINTIFF01116369-01116373: "We have not been able to reconcile to the premium information CMS used for the Risk Corridors and need Edge server data (with identifiers) to do so."

[169] Chereb, S. "Report: No quick fix for Nevada health exchange". Las Vegas Sun, dated April 29, 2014. Available at https://lasvegassun.com/news/2014/apr/29/report-no-quick-fix-nevada-health-exchange/.

[170] "Nevada, Xerox in private talks to settle $75 million health care contract out of court". Las Vegas Sun, dated October 1, 2014. Available at https://lasvegassun.com/news/2014/oct/01/nevada-xerox-private-talks-settle-75-million-healt/.

[171] The Associated Press. "Suit filed against Xerox, Nevada health exchange". Reno Gazette Journal. April 2, 2014. Available at https://www.rgj.com/story/news/2014/04/02/suit-filed-xerox-nevada-health-exchange/7214399/. Roerink, K. "Another disgruntled group files suit against Xerox and state". Las Vegas Sun, dated August 27, 2014. Available at https://lasvegassun.com/news/2014/aug/27/class-action-lawsuit-targets-xerox-and-state/.

[172] Ornick, K. "Mass of people slipping though big cracks in state health exchange". Las Vegas Sun, dated June 22, 2014. Available at https://lasvegassun.com/news/2014/jun/22/mass-people-slipping-through-big-cracks-state-heal/.

[173] Roerink, K. "Another disgruntled group files suit against Xerox and state," Las Vegas Sun, dated August 27, 2014. Available at https://lasvegassun.com/news/2014/aug/27/class-action-lawsuit-targets-xerox-and-state/.

[174] Joint Stipulation of Settlement and Release. Lawrence Basich et. al. v. Xerox State Healthcare, LLC; and Patrick Casale, et. al. v. Xerox State Healthcare, LLC. (September 9, 2016). Case No. A-14-706171-C.

[175] Complaint. State of Nevada, Ex. Rel. Commissioner of Insurance, Barbara D. Richardson v. Silver State Health Insurance (June 5, 2020). Case No: A-20-816161- C.

[176] Silver State Health Insurance Exchange's Answer. State of Nevada, Ex. Rel. Commissioner of Insurance, Barbara D. Richardson, In Her official Capacity as a Receiver for Nevada Health CO-OP v. Silver State Health Insurance Exchange. A-20-816161- C.

The ongoing issues and challenges NHC experienced with the Exchange and Xerox were significant factors impacting claims processing.[177] NHC's Board minutes frequently identified these difficulties:[178]

- NHC was speaking regularly with the Governor as well as other carriers regarding the challenges with data submissions from Xerox to NHC.
- NHC did not receive any information on 3,000 members from Xerox due to the Exchange's on-going data transfer failures.
- The letter prepared by NHC attorneys to Xerox and the Governor outlining problems NHC was having with the Exchange and Xerox.[179]
- How Xerox has and continues to hurt NHC's credibility in the market place and injured NHC members.
- An example of a New Year's Eve heart attack patient being left with a $410,000 bill and unmanaged care due to Xerox failing to inform NHC that the patient was an NHC member.

Below are additional key issues regarding difficulties NHC was having with Xerox and the State Exchange:

- Xerox admitted its payment collection process was working at only 45 percent capacity.
- The possible extension of payment deadlines for consumers past May 30th since 4,000 consumers wanted to pay their premiums but were unable to due to Xerox system errors.
- Xerox presented NHC with a report of 900 delinquent members dated back to January 2014 that was never timely reported and of which NHC was unaware.[180]
- Xerox had an overall, and undeniable, negative impact on NHC's finances. NHC committed 50 percent of its resources to Xerox and Xerox-related issues starting in October 2013.[181]

The Silver State Health Insurance Exchange concluded that Xerox data was unreliable.[182]

- "The Exchange, as a dedicated partner to the carriers, recognize that we collectively can no longer rely on Xerox data."
- "Xerox's efforts at reconciliation over many months have not led to a timely closure of the issues and do not appear to offer the potential for resolution in the future."

[177] NHC Board of Directors Minutes for February 19, 2014. LARSON014367-014370 at 14367-68.
[178] NHC Board of Directors Minutes for February 19, 2014. LARSON014367-014370 at 14367-68.
[179] Letter from Tom Zumtobel, Chief Executive Officer of NHC, to Governor Brian Sandoval and Will Saunders, President of Xerox State Healthcare, LLC, dated February 24, 2014. UHH0353824-0353827.
[180] NHC Board of Directors Minutes for May 23, 2014. LARSON014384-014390 at 014388.
[181] NHC Board of Directors Minutes for May 23, 2014. LARSON014384-014390 at 014388.
[182] Email between Steve Fitzsimmons, Managing Associate General Counsel of Anthem Blue Cross Blue Shield, and Damon Haycock, Silver State Health Insurance Exchange, Regarding Redline edits to Proposed Reconciliation Plan; NOPHI, dated March 6-26, 2015. PLAINTIFF01096199-01096204 at 01096200 & 01096203.

Further, NHC budget overruns were due in part to the transition from the State Exchange to the Federal exchange. As reflected in NHC's September 2014 Board minutes, one reason administrative costs were higher than the budgeted amount was IT (information technology) expenses were higher than expected due to the shift from the State to the Federal exchange for direct enrollment.[183]

The preceding discussions make it clear that NHC did not fail because of any activities of UHH and/or NHS.[184] Instead, it failed because the entire Federal CO-OP program failed and because NHC's claims costs substantially exceeded its premium revenues. In other words, if UHH and NHS had performed perfectly, NHC would still have failed.

8. Osowski's Opinions Fail to Establish UHH and/or NHS as the Cause for NHC's Failure

Henry Osowski's (Osowski) report includes a set of opinions, some of which relate to UHH, and a list of damages he attributes to UHH. Osowski does not calculate these damages. Instead, he simply accepts the damages listed by Plaintiff's expert Mark Fish (Fish) in his report without any independent validation. In addition, Fish has accepted many of the damage amounts calculated by the Special Deputy Receiver (SDR) in its draft report. For this reason, I do not address Osowski's damages presentation in this section. The damages discussion is presented in my subsequent analyses of the Fish and DRAFT SDR reports.

In his report, Osowski identifies 28 opinions that relate to his belief that UHH and the NHC Management Defendants, IM, and NHS performed at levels below industry standards and failed to act in the best interests of NHC.[185] Eighteen of his opinions relate to UHH and the NHC Management Defendants.[186] Based on these opinions, Osowski concludes that NHC suffered damages due to UHH's failure to perform its duties and for contributing to NHC's ill prepared commencement of operations.[187] He makes no effort to (i) identify how each of his opinions caused NHC to be ill prepared to commence operations: (ii) account for the issues discussed in Sections 6 and 7 of this report regarding the failure of the Federal CO-OP program and NHC's unexpectedly high medical costs which were the primary causes of NHC's failure; or (iii) identify and explain the substantial vetting and guidance that NHC received from both CMS and industry experts prior to selling policies or commencing operations on the initial open enrollment date of October 1, 2013.

[183] NHC Board of Directors Minutes for November 25, 2014. LARSON014417-014421 at 014419-20.
[184] See also NHC Board of Director Minutes for October 18, 2014, "A discussion of the financials indicated that the September financials will show significant changes as additional information has become available, including a revised IBNR from Milliman. The CO-OP expects a high MLR and a significant, but not unexpected loss at the end of the first year of operations. As expected, this is due to pent up demand for medical care, new relationships with providers and with members. In addition, the CO-OP had significant unplanned expenditures resulting from the failure of the State Exchange system, the move from the State System to the FFM, and the addition of direct enrollment, payment and billing responsibilities to CO-OP operation." LARSON014414-014416 at 014414.
[185] Osowski Report II, pp. 6-12.
[186] Osowski Report II, pp. 6-9.
[187] Osowski Report II, pp. 71-73.

Osowski lists 18 opinions related to UHH and the NHC Management Defendants that I have grouped into three categories:

- Opinions related to the process of selecting UHH as NHC's TPA and UHH's capabilities to serve as NHC's TPA;
- Opinions related to the alleged conflict of interest between UHH and NHC that Osowski perceives; and
- Opinions based on UHH's alleged failures to meet industry and contractual standards.

In this section, these three categories are used to guide the discussion of Osowski's 18 opinions. I first provide an overview of CMS' oversight and NHC's reliance on industry experts during commencement operations and then discuss each of the three categories.

8.1 Oversight of NHC's Commencement of Operations

As previously discussed, the CO-OP program was established under the ACA which gave CMS the authority to provide loans to capitalize the CO-OPs. As stated by the Commissioner/Receiver, "NHC and its predecessors in interest were formed to provide health insurance to individuals and small businesses under the federal [ACA]."[188] In order to receive a loan, CO-OPs, including NHC, went through a rigorous application process. The Catalog of Federal Domestic Assistance (CFDA) Number: 93.545 described the funding opportunity for the CO-OP program start-up and solvency loans.[189] The grant application required voluminous documentation categorized into thirteen sections[190]:

1. Standard Forms,
2. Application Cover Letter,
3. Application Abstract,
4. Project Narrative,
5. Feasibility Study,
6. Business Plan,
7. Governance and Licensure,
8. Evidence of Nonprofit Status,
9. List of Relevant Statutory and Regulatory Citations Regarding State Licensure,
10. Eligibility Affidavit and Application Certification,
11. Affidavits(s) of Criminal and/or Civil Proceedings,

[188] Amended Complaint. State of Nevada, Ex Rel. v Milliman, Inc., et al. (September 24, 2018). ¶ 2.
[189] CCIIO. "Initial Announcement Invitation to Apply". CMS, dated July 28, 2011. CFDA: 93.545.
[190] CCIIO. "Initial Announcement Invitation to Apply". CMS, dated July 28, 2011. CFDA: 93.545, pp. 30-37.

12. Affidavit of Eligibility to Participate in Federal Programs, and

13. Evidence of Private Support.

On January 1, 2012, HH, the predecessor to NHC, submitted its grant application package for Catalog of Federal Domestic Assistance (CFDA) Number: 93.545.[191] HH's grant application package was 653 pages.[192] Per the Invitation to Apply to CFDA: 93.545, "The business plan is the most important component of the application, and is weighted at 62 percent of the application review score."[193] NHC relied on Milliman to render actuarial opinions in preparing a significant portion of the business plan and the entire feasibility study. Milliman expected that sections of their report would be integrated "directly into the application"[194] and that their full report included as an attachment to the application.[195] Milliman provided assistance for the following items in the grant application:[196]

- Feasibility Study
- Process for determining accurate and appropriate pricing of premiums
- Enrollment Forecast
- Regulatory Capital Requirements Forecast
- Pro Forma Financials including cash flow statement, balance sheet, and income statement
- Risk bearing strategy

Per Milliman, "The Feasibility Study and the Business Plan must fit together and elements from one are required for completion of the other."[197] Based on their analysis, Milliman's found that[198]:

The results of our analyses suggest that HHC will be able to achieve the following goals:

- Achieve sufficient market penetration to support its expenses
- Meet statutory minimum loss ratio requirements,
- Maintain a surplus level in excess of the minimum required to avoid Department of Insurance oversight,
- Generate enough surplus to repay its federal loans.

It should be noted that Milliman completed the analyses that are included in the business plan and feasibility study without assuming any risk sharing gain or loss due to lack of data needed to make a reasonable estimate.[199] Therefore, even without the risk sharing protections established by the ACA, Milliman concluded that NHC would be financially viable and able to meet its financial obligations.

[191] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343.
[192] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343.
[193] CCIIO. "Initial Announcement Invitation to Apply". CMS, dated July 28, 2011. CFDA: 93.545, p. 32.
[194] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT002725.
[195] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT002729.
[196] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT002730-MGT002731.
[197] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT002731.
[198] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT002732.
[199] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT002758.

The business plan evidences NHC's commitment to building a well-qualified team by enlisting organizations, leaders, contractors, and consultants with industry experience[200]:

- Sponsors: UHH and the Nevada Health Services Coalition
- Management Team (resumes included in application): Tom Zumtobel, Vice President of Strategy for UHH (CEO): Kevin Gittens, Chief Financial Officer for UHH (CFO); Bobbette Bond, Executive Director of the Nevada Healthcare Policy Group and Director of Public Policy of the CHF (CPO): Pei Tang, Vice President, Healthcare Informatics and Outcomes of ALERE (CIO)
- Formation Board of Directors: Kathy Silver, President of the CHF; Jeff Ellis, Vice-President and CFO of Corporate Benefits of MGM Resorts International; Tom Zumtobel, Vice President of Strategy for UHH; Bobbette Bond, Executive Director of the Nevada Healthcare Policy Group; Andy Brignone, Shareholder in the law firm Brownstein Hyatt Farber Schreck; Betsy Gibertson, Chief of Strategy for UHH; D. Taylor, Secretary-Treasurer of Culinary Workers Union Local 226 in Las Vegas, and Vice President and Gaming Division Director of UHH
- Contractors:
    - CHF: "During the first year of the plan's implementation in the Las Vegas area, HHC will contract with CHF 's Las Vegas office for a variety of health care management services, the data warehouse, and access to the CHF provider network for CO-OP members."[201]
    - UHH: "HHC will subcontract the initial plan enrollment, administration and management to UNITE HERE HEALTH through its Las Vegas office, the Culinary Health Fund."
    - Health Services Coalition: Hospital network
    - Milliman: "HHC will subcontract with Milliman for actuarial services in support of premium pricing, targeting, policy development, and budgets."
    - InsureMonkey and Ceridian Exchange Services, LLC: "InsureMonkey (or an entity with similar capacity) will develop the online enrollment system, including a link from the HHC website to the Nevada Silver State Exchange so that members may select HHC on the Exchange, enroll electronically, and pay premiums online."
    - American Health Holding: Cost management products
    - Catalyst Rx: Pharmacy benefits management
- Consultants:
    - Insurance Licensing Services: to be determined
    - Clinical Service Improvements: Arnold Milstein, MD, MPH and Brain Trust
    - Marketing Consultant: Richard Ross

Applications were reviewed by an "objective review panel of qualified external experts with applicable knowledge and experience" with CMS making the award decision.[202] The loan agreement between CMS

[200] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT002763-MGT002769.
[201] "Hospitality Health CO-OP (HHC)". Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT002714.
[202] CMS. CFDA: 93.545. Dated July 28, 2011. See also, "To assist CMS in awarding CO-OP loans, we have obtained services from Deloitte Consulting, LLP to establish, and manage qualified expert, objective technical panels

and HH was closed on May 17, 2012.[203] In 2013, the Nevada Department of Insurance reviewed and approved the CMS/NHC loan agreement.[204]

Under the loan agreement, start-up funding disbursements were contingent upon NHC meeting specific conditions and milestones.[205] NHC had nearly 100 milestones to complete to obtain funding.[206] Furthermore, each milestone required completion of predecessor milestones and submission of documentation to CMS.[207] The disbursement schedule required that most of the milestones needed to commence operations were to be completed prior to the first enrollment period.[208] Osowski opines that commencement activities were failures due to UHH, but such activities were the responsibilities of NHC and were primarily performed by NHC,[209] and overseen by CMS under the disbursement schedule.[210] Additionally, NHC and its CMS account manager (AM) had regularly scheduled status calls starting in June of 2012 to discuss NHC's milestone activities, review and request required documentation, and answer questions.[211]

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responsible for reviewing applications and providing recommendations to CMS staff." See https://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.

[203] Loan Agreement. LARSON000782-000863.

[204] Declaration of Mark F. Bennett. Barbara D. Richardson v. The United States, dated September 9, 2020. Case 1:18-cv-01731-MHS.

[205] 3.8. Conditions Precedent for Loan Disbursement of Loan Agreement. LARSON000782 at LARSON000797-98. See also, "Mr. Zumtobel expressed that CMS is providing significant oversight using the disbursement schedule and milestone project plan." HH Board of Directors Minutes for June 15, 2012. PLAINTIFF01145759-01145763 at 01145760.

[206] Loan Agreement. LARSON000782-000863. CO-OP Program Start-Up Loan Detailed Disbursement Schedule. UHH0358131.

[207] Loan Agreement. LARSON000782-000863; and CO-OP Program Start-Up Loan Detailed Disbursement Schedule. UHH0358131.xlsx. See also: UHH0515427; UHH0515424; UHH0578455; UHH0578426; UHH0578538; UHH0578537; PLAINTIFF00927838; PLAINTIFF00927837; PLAINTIFF00620046; PLAINTIFF00620043; PLAINTIFF00616404; PLAINTIFF00616402; PLAINTIFF00638092; PLAINTIFF00638090; UHH0532726; UHH0532724; PLAINTIFF00410478; PLAINTIFF00410475; PLAINTIFF00387709; PLAINTIFF00387707; PLAINTIFF00355369; PLAINTIFF00355366; PLAINTIFF00352965; PLAINTIFF00352965; PLAINTIFF00784962; PLAINTIFF00784960; PLAINTIFF00784961; PLAINTIFF00572020; PLAINTIFF00436143; PLAINTIFF00436141; PLAINTIFF00460374; PLAINTIFF00460376; PLAINTIFF00460373.

[208] Loan Agreement. LARSON000782-000863. CO-OP Program Start-Up Loan Detailed Disbursement Schedule. UHH0358131.xlsx

[209] Executive Services Agreement between Unite Here Health, Hospitality Health, Ltd., and Thomas Zumtobel dated September 13, 2012. PLAINTIFF00912140-00912150. Executive Services Agreement between Unite Here Health, Hospitality Health, Ltd., and Bobbette Bond, dated September 13, 2012. UHH0000076-0000089. (Executive Services Agreements). HH Board of Directors Minutes dated December 10, 2011. PLAINTIFF00457385-PLAINTIFF00457389. (UHH provided assistance under the Consulting Agreement between UHH and NHC dated as of January 30, 2013, to be effective as of May 17, 2012. PLAINTIFF00523772. The Executive Services Agreements and Consulting Agreement were negotiated at arm's length through separate legal counsel for each side). See Exhibit 4.

[210] Loan Agreement. LARSON000782-000863. CO-OP Program Start-Up Loan Detailed Disbursement Schedule. UHH0358131.xlsx

[211] HH Board of Directors Minutes dated June 15, 2012. PLAINTIFF01145759-01145763 at 01145760. See also, UHH0606924; UHH0607054; UHH0607052; UHH0554101; UHH0577231; UHH0553828; UHH0553668; UHH0553652; UHH0553499; UHH0577255; UHH0599149; UHH0577186; UHH0577188; UHH0553213; UHH0552955; UHH0552873; UHH0551149; UHH0551153; UHH0577126; UHH0577134; UHH0551684;

CMS had broad oversight power under the loan agreement.[212],[213] On August 15, 2013, CMS conducted a site visit at NHC,[214] and it was reported to the board that "CMS was satisfied with the CO-OP's operational progress."[215] However, the Onsite Visit Summary Report indicated the overall status of the CO-OP was delayed and noted areas of strengths as well as concerns.[216]Additionally, in 2013, PricewaterhouseCoopers LLP (PwC) audited NHC for the purpose of assisting "CMS in its assessment of Nevada Health CO-OP's compliance with certain provisions of its loan agreement."[217] The audit report with NHC's responses was submitted to CMS by NHC on February 10, 2014.[218]

Most importantly, CMS could elect to terminate NHC's loan agreement and cease distributions for program viability reasons:

> "Lender may elect to terminate this Agreement if it determines in its sole and absolute discretion that Borrower will not be likely to be able to establish a viable and sustainable CO-OP that serves the interests of its community and the goals of the CO-OP Program…."[219]

Yet, CMS made all disbursements for milestones through Q2 2014 totaling $16,930,047.00 by December 31, 2013 evidencing CMS considered all predecessor milestones complete and required documentation sufficient.[220]

It is clear that CMS concluded that NHC was, in fact, prepared to commence operations as of the first open enrollment period.

UHH0551131; UHH0551659; UHH0555008; UHH0551289; UHH0577156; PLAINTIFF00784783; PLAINTIFF00930537; PLAINTIFF00624267; PLAINTIFF00623909; PLAINTIFF00690235; PLAINTIFF00622602; PLAINTIFF00970237; PLAINTIFF00590675; PLAINTIFF00686876; PLAINTIFF00912439; PLAINTIFF00453089; PLAINTIFF00437223; PLAINTIFF00080351; PLAINTIFF00453197; PLAINTIFF00784478.

[212] Loan Agreement. Section 11. LARSON000782-000863 at 000810.

[213] Levinson, D. "Early Implementation of the Consumer Operated and Oriented Plan Loan Program". Department of Health and Human Services: Office of Inspector General, dated July 2013. OEI-01-12-00290. Available at https://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf.

[214] Email from Michele Schultz, CEO Executive Assistant of NHC, to KSilver; Christine Carafelli; and Jeffrey Ellis, Regarding CMS Site Visit Agenda, dated August 14, 2013. PLAINTIFF00911104. See also Agenda of Nevada Health CO-OP Site Visit – August 15, 2013. PLAINTIFF00911105.

[215] NHC Board of Directors Minutes for August 16, 2013. LARSON000680-LARSON000683 at 000680.

[216] Email from COOP-CMS-TA-Support to Tom Zumtobel, Chief Executive Officer of NHC, Regarding Attached: Nevada Onsite Visit Summary Report, dated October 18, 2013. PLAINTIFF00958700-00958701. CCIIO. "CO-OP Onsite Visit Summary Report". CMS, dated October 2013. PLAINTIFF00958702-00958710.

[217] PwC. "Nevada Health CO-OP Performance Audit Report", dated January 28, 2014. PLAINTIFF00452852-00452883.

[218] Email from Basil Dibsie, Chief Financial Officer of NHC, to Tanchica Terry, CMS/CCIIO, Regarding PWC Audit, dated February 10, 2014. PLAINTIFF00452851. See also PwC. "Nevada Health CO-OP Performance Audit Report", dated January 28, 2014. PLAINTIFF00452852-00452883.PLAINTIFF00452852.

[219] Loan Agreement. Section 16.2. LARSON000782-000863 at 000820-21.

[220] Loan Agreement. LARSON000782-000863. CO-OP Program Start-Up Loan Detailed Disbursement Schedule. UHH0358131.xlsx See also Nevada Health CO-OP Trial Balance as of December 31, 2012. LARSON000154-000157. See also Nevada Health CO-OP General Ledger as of December 31, 2013. LARSON000171-306.

8.2 UHH was Prepared and Capable of Providing TPA Services to NHC

Osowski's opinions regarding the process of selecting UHH as NHC's TPA and UHH's capability to serve as NHC's TPA are addressed in this section. The relevant Osowski opinions are[221]:

1. It is an industry standard procedure to conduct proper due diligence and analyze the knowledge, experience and past performance of potential Third-Party Administrator ("TPA"), including those with adequate experience and information technology capabilities prior to the selection of a TPA.
2. Prior to the selection of UHH as NHC's TPA there was no detailed documentation of NHC's functional business requirements or any known detailed information technology system design for NHC's needs. UHH lacked the knowledge and experience relative to multi-line commercial health insurance products to appropriately produce such documentation.
3. It is an industry standard procedure and information technology best practice to create detailed documentation of the functional needs of an insurer and a detailed information technology system design prior to selecting an insurance administration platform.
4. At the time of the selection of UHH to provide TPA services to NHC and thereafter, there were several qualified TPAs with multi-product commercial experience and adequate information technology systems to capably service NHC.
5. At the time of selection of UHH, UHH was inexperienced in servicing multi-product commercial insurance plans and incapable of meeting the functional business needs of a multi-product commercial health insurer like NHC.
6. UHH was unprepared to properly support the functional business requirements of NHC and unwilling to meet the reasonable performance requirements of the CO-OP Program.

UHH's TPA contract met CMS' requirements. Osowski's opinion that the Administrative Services Agreement (ASA) between NHC and UHH was not industry standard and weighted against NHC has no foundation. UHH has been successfully providing administrative services for decades.[222] Between 2012-2015, for non NHC plans, UHH paid over 1.7 million claims, consisting of 4.6 million claim lines, for plans with an average of 57,000+ members per year.[223] Under the ASA, UHH agreed to "provide the administrative services with such skill and care as [UHH] has exercised historically in providing similar services to itself and consistent with industry-recognized standards."[224] As discussed, the loan agreement required disbursement of start-up funding to be contingent upon the CO-OP meeting specific conditions and milestones.[225] A portion of the CO-OPs disbursement for business structuring activities was to approve a Contract with Fund/vendor for Third Party Administrator(TPA) services.[226] Although

[221] Osowski Report II, p. 6.
[222] Unite Here Health. "Mission & Overview". Available at https://www.uhh.org/about.
[223] UHH0632395.
[224] ASA. ¶2.1.
[225] 3.8. Conditions Precedent for Loan Disbursement of Loan Agreement. LARSON000782-000863 at LARSON000797-98.
[226] Appendix 1 – Schedule A: Start-Up Disbursements and Milestones of Loan Agreement. LARSON000782 at LARSON000834.

CMS suggested that the CO-OP Program Performance Requirements and Service Level Standards be incorporated into the ASA,[227] CMS distributed funds for this milestone without their recommended performance standards or financial penalties.[228] CMS' concerns with the ASA were reported to the NHC Board of Directors and performance standards were not an issue[229]:

> **IV. Administrative Services Agreement Status**
>
> Mr. Zumtobel stated that there are four (4) outstanding issues with CMS for approval: connect the ASA to the Business Plan, estimate it against the budget, adjust how they will use the Fund, and build Claims into the budget number. Mr. Landahl added that the cost incurred was factored into the original Business Plan.

Osowski's opinion that, "the CMS recommended performance standards, including stated national benchmarks and financial penalties, were reasonable and should have been incorporated in the ASA"[230] is not supported by CMS' actions.

Further, Osowski ignores the important point that UHH's historical performance standards were similar to CMS's CO-OP Program Performance Requirements and Service Level Standards. For example, based on historical performance, UHH expected 90 percent of the claim volume to come from electronically submitted claims[231] while the CMS' standards cited an 88 percent standard for claims received electronically.[232]

Osowski's comments regarding system design requirements are wrong. As discussed, under the loan agreement, start-up funding disbursement was contingent upon the CO-OP meeting specific conditions and milestones.[233] In order to obtain QTR 3 2012 funding related to the establishment of the claims system, the CO-OP had to "Identify vendor options for claims system," "Identify three potential vendors for claims system as well as review criteria for vendor selection," and provide a "Description of three

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[227] Email from Tanchica Terry, CMS/CCIIO, to Tom Zumtobel, NHC, Regarding Core Contract Review: TPA Agreement, dated July 26, 2013. PLAINTIFF00685281-00685283. See also Email from Tanchica Terry, CMS/CCIIO to Tom Zumtobel, NHC, Regarding Nevada Sample Contract Language and Performance Standards, dated July 30, 2013. UHH0290495-0290496.; and Performance Requirements and Service Level Standards UHH02904970-0290507.

[228] Account Manager Approval for Start-up Loan Disbursement, dated December 10, 2013. PLAINTIFF00436143-00436145. Account manager comments, "The core contract have been reviewed and approved by CMS." See Email from Michele Schultz, CEO Executive Assistant of NHC, to Tanchica Terry, CMS/CCIIO and Nicole Gordon, CMS/CCIIO, Regarding Nevada Health CO-OPO Disbursement Request, dated October 31, 2013. PLAINTIFF00638090 and Attachment 2: Start-up Loan Disbursement Request Form, dated October 31, 2013. PLAINTIFF00638092.xlsx.

[229] HH Board of Directors Minutes for December 12, 2012. UHH0533093-UHH0533095.

[230] Osowski Report II, p. 14.

[231] Email between Michael Gulling, Director, Claims Department of UHH, and Randy Plum, Director of Operations of NHC, Regarding Print to EDI, dated February 28, 2014. PLAINTIFF00049070-0049071 at 00049070.

[232] Performance Requirements and Service Level Standards. PLAINTIFF02476934-02476944 at 02476936.

[233] 3.8. Conditions Precedent for Loan Disbursement of Loan Agreement. LARSON000782-000863 at LARSON000797-98.

vendors and products under consideration for enrollment system."[234] In order to obtain QTR 4 2012 funding related to the establishment of claims system, the CO-OP had to select a claims system vendor and provide a "Description of vendor desired for claims system with description of needs," and a "Signed contract for claims system and implementation schedule."[235] As reflected in Exhibit 5, a robust claims system evaluation of three vendors was performed by a claims system steering committee. The vendors were Healthation, Eldorado, and TriZetto. Each vendor responded to informational requests, provided details on functionality, assessed system needs, presented system demos, and participated in on-site meetings.[236] The CO-OP was fully funded for the establishment of the claims system on December 20, 2013.[237] The CMS account manager approved the start-up loan disbursement when all predecessor milestones were complete and the core contract was reviewed.[238] However, claims processing issues were not due to the lack of a system design or the functional capabilities of Javelina, but as discussed, were due to the compressed timeline to launch a health plan, the inability to get accurate membership information from the State Exchange and Xerox, the high percentage of paper claims, NHC's inability to provide benefit plan and fee schedule information to UHH on a timely basis, and other daily operational issues (as discussed in detail in the CCI Report).

8.3 NHC Was Not Disadvantaged by the Relationship between UHH and the NHC Management Defendants

Osowski's opinions Nos.7 through 11 are discussed in this section. These opinions are:

7. NHC was disadvantaged in negotiations between NHC and UHH as certain NHC management was employed by UHH and was concurrently serving leadership positions with both NHC and UHH thereby creating a significant conflict of interest.
8. Management Defendants ignored the warnings of NHC's attorneys that the contracts with UHH were not industry standard and refused to change provisions that UHH wanted.
9. Management Defendants ignored the comments of CMS that the contracts with UHH were not industry standard and refused to change provisions that UHH wanted.
10. Were it not for the conflict of interest between NHC Management and UHH, it is unlikely that NHC, as an independent organization, would have contracted for TPA services with UHH, an organization that it knew, or should have known, did not have the experience, information technology support or qualifications to perform the required TPA services.
11. Were it not for the conflict of interest between NHC Management and UHH, it is unlikely that NHC would have agreed to the provisions contained in the agreements with UHH.

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[234] Appendix 1 – Schedule A: Start-Up Disbursements and Milestones of Loan Agreement. LARSON000782-000863 at LARSON000835.
[235] Appendix 1 – Schedule A: Start-Up Disbursements and Milestones of Loan Agreement. LARSON000782-000863 at LARSON000836.
[236] See Exhibit 5.
[237] Email from Terry Tanchica (CMS/CCIIO) to Basil Dibsie, Director of Finance for NHC Regarding Disbursement Request for Core Contract Funding, dated December 31, 2013. PLAINTIFF00436141 – 00436142 at 00436141.
[238] Account Manager Approval for Start-up Loan Disbursement for NHC, dated October 31, 2013. PLANTIFF00436143-00436145 at PLANTIFF00436145.

CMS' issues with NHC management personnel working for UHH were resolved. Osowski claims that UHH's activities were affected because NHC managers were employed by UHH, but this arrangement was acceptable to CMS. The NHC management team and Board of Directors were approved by CMS (with full knowledge of the nature of the professional relationships of NHC managers and Board members being affiliated with UHH) during the CO-OP eligibility review and loan application process.[239] In fact, CMS expected the CO-OP to hire an experienced management team; one of the permitted uses of the CMS loan funds was for costs associated with "Hiring a management team with **adequate insurance expertise**…."[240] (Emphasis added.) The executive services agreement was reviewed and accepted by CMS.[241] Further, it is clear from the documentation that CHF, UHH, and NHC exercised care to disclose any potential conflicts of interest and NHC had non-UHH management personnel making key operational decisions, Ms. Egan (the CO-OP CEO, eff. Nov. 15, 2014), Ms. Mattoon, Ms. Harris, Dr. Flora, Mr. Dibsie, Mr. Plum, Ms. Sandoval, Ms. Simons, Ms. Rodriquez, Ms. Manchester, Mr. Knapp, and others, were directly responsible for daily CO-OP operations.[242]

In its Grant Application Package, NHC, as successor to Hospitality Health, Ltd., disclosed that, "Hospitality Health, Ltd. was founded in 2011 by the Culinary Health Fund of Las Vegas, a Taft-Hartley health plan; its parent organization UNITE HERE HEALTH; and the Nevada Health Services Coalition."[243] Leaders from these organizations created the NHC formation board and NHC planned to use this "highly qualified management team" to "replicate [CHF's] successful administrative and service delivery structure."[244] CHF was NHC's sponsoring entity and it was specifically disclosed to CMS that "CHF pledged ongoing private financial support in the amount of $575,000" and would "waive CHF's network access fee of $1 per member per month" an estimated savings on average of $488,688 per year for the first three years.[245] CMS was clearly aware of the relationships between NHC, CHF, and UHH. While CHF and UHH would have supportive roles, NHC would be the entity held responsible by CMS.[246]
NHC's formation Board of Directors were aware that CMS had questions about NHC's relationship with UHH[247] and addressed them. Board of Directors minutes describe CMS' questions and the answers that were provided[248]:

[239] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343.
[240] 3.5. Permitted Use of Loan Funds of Loan Agreement. LARSON000782-000863 at LARSON000795.
[241] Email between Darryl Landahl, Brownstein Hyatt Farber Schreck, LLP, and Johanna Fabian-Marks, CMS/OL, Regarding HH Executive Services Agreements – CO-OP Program Questions, dated July 5-18, 2012. UHH0553556-0553558.; Email between Johanna Fabian-Marks, CMS/OL, and Lindsey Levenberg, CHF, Regarding HH Executive services contracts, dated July 27, 2012. UHH0543438-0543440.
[242] CCI Report.
[243] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at 002709.
[244] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at 002709.
[245] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at 002711.
[246] HH Board of Directors Minutes for December 10, 2011. PLAINTIFF00457385-PLAINTIFF00457389.
[247] HH Board of Directors Minutes for May 4, 2012. UHH360458-0360468 at 0360459.
[248] HH Board of Directors Minutes for May 7, 2012. PLAINTIFF01461068-PLAINTIFF01461075 at PLAINTIFF01461071.

Mr. Zumtobel explained they had a CMS call on Friday and that there had been some new issues raised. He said it was interesting because CMS didn't even raise the issues on today's call. He adds that he believes the board should be aware of it and that the issue is on how they are reaping services from the fund and how when he and Ms. Bond are both employed by the fund but contracted employees with the COOP would they make sure to keep the right check and balances in place. He explained that the Fund is not for profit and that the COOP and Fund have common mission serving their members first and are completely aligned and are in a fully transparent relationship.

Mr. Ellis asks, was there any concern expressed that the COOP would be used for the benefit of the Union or anything of that sort?

Ms. Bond replies no and that her impression was that they are only funding COOPs that seem to have a strong support system in place and that can work with CMS short timeframes. She continues and says that it seemed that those who have been funded either have history of a COOP or have a strong support system in place like theirs. Believes CMS views as all benefiting and COOP will be able to thrive. The only issue CMS had was to be sure that whatever is touched there is no conflict.

The management of NHC was ultimately the responsibility of the Board of Directors.[249] The formation Board of Directors made certain that key functions would be separated. For example, "The Accounting department will be an external entity. This came from a recommendation from one of the Fund Trustees to avoid NHC funding being in any way the responsibility of the Fund Staff."[250]

CMS was fully aware of NHC's management structure and its relationships to UHH, approved NHC's loan application, and fully funded NHC's executive services contracts.

The ASA was not weighted against NHC as Osowski claims. UHH was fully aware that it could not earn a profit from its relationship with NHC, and provided administrative services at cost.[251] In addition, the NHC Board had Mercer undertake a market analysis to assure the reasonableness of UHH's pricing.[252] Mercer found that UHH's pricing was competitive,[253] and that "given the not-for-profit structure of both parties, a financial penalty for non-performance would not be a viable approach in this situation."[254]

[249] Nevada Hospitality Health CO-OP Grant Application Package. MGT002691-MGT003343 at MGT003047-003060.
[250] HH Board of Directors Minutes for May 4, 2012. UHH360458-0360468 at 0360462.
[251] HH Board of Directors Minutes for May 4, 2012. UHH360458-0360468 at 0360460.
[252] NHC Board of Directors Minutes for October 16, 2013. LARSON000689-LARSON000692 at 000692. See also Email from Denise P. Jewell, CPA, CLU, Principal of Mercer, to Tom Zumtobel, NHC, Regarding Final Documents – Mercer Study for NV Co-op, dated December 13, 2013. PLAINTIFF00896007.
[253] Jewell, D. "Nevada Health Co-op Benchmarking Project". Mercer, dated December 2013. PLAINTIFF00896008-00896021 at 00896009. Self-Funded, Network Access, Administrative, and Other Fees Tables. PLAINTIFF00896022-00896026.
[254] Jewell, D. "Nevada Health Co-op Benchmarking Project". Mercer, dated December 2013. PLAINTIFF00896008-00896021 at 00896018.

Additionally, Osowski claims that the ASA was "thrust upon NHC" and negotiated by related parties.[255] Pursuant to a conversation with UHH, I have been able to confirm that the ASA was negotiated at arm's length through separate legal counsel for each side. I have had an opportunity to review some,[256] but not all documents related to these negotiations, and I may modify my report after I have had an opportunity to complete my review.

Transactions between related parties commonly occur in the normal course of business. When an entity has an affiliate that has the capability to perform needed functions for the entity, it often finds advantages in working with the affiliate rather than a previously unknown vendor. This is especially true in the health insurance industry. For example, a small group of Blue Cross and Blue Shield plans created a mental health utilization management company and then turned that function over to the new entity. South Carolina Blue Cross and Blue Shield created an independent company (TriZetto) to provide its claims processing system and United Healthcare created Optum and contracted with it to perform several of United's activities. In fact, "the Receiver has availed herself of the services of the SDR's affiliate, Palomar Financial, LC ("Palomar") "…. in her receivership of the CO-OP.[257]

8.4 UHH Properly Performed TPA Services

This section discusses the following opinions cited by Osowski[258]:

12. The Administrative Services Agreement ("ASA"), and the earlier Consulting Agreement entered into between Nevada Health CO-OP ("NHC") and Unite Here Health ("UHH") were not industry standard, were materially unfavorably weighted against NHC, and failed to include appropriate performance standards and measures, as well as penalties for non-performance.
13. UHH failed to meet industry and contractual standards under the contracts with UHH.
14. Given UHH's failure to be registered with the Nevada Division of Insurance ("DOI") as a third-party administrator, and UHH's lack of any TPA experience for a multi- plan commercial enterprise, it was a violation of industry standards of care to select and retain UHH as NHC's TPA.
15. Further, NHC management's and UHH's failure to comply with the Centers for Medicare and Medicaid Services ("CMS") contract review and approval requirements, CMS' CO-OP Performance Requirements and Service Level Standards and Nevada DOI TPA registration requirements were further examples of what would become a pattern of non-compliant behavior with industry standards, statutory requirements and regulatory requirements by both NHC's management and UHH.

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[255] Osowski Report II. Page 13.
[256] Email between Cara S. Elias of Brownstein Hyatt Farber Schreck, LLP, and Bobbette Bond, MPH, Project Officer of NHC, Regarding TPA and UM Agreements, dated June 12-18, 2013. PLAINTIFF02476718-02476736. Email between Cara S. Elias, Brownstein Hyatt Farber Schreck, LLP, and Bobbette Bond, MPH, Project Officer of NHC, Regarding TPA and UM Agreements, dated June 17, 2013. PLAINTIFF02424600-02424603. UHH0632186.
[257] First Status Report. State of Nevada, Ex Rel. v. Nevada Health CO-OP (January 13, 2016). Case No. A-15-725244-C.
[258] Osowski Report II, pp. 7-9.

16. The lack of functional business requirements documentation and a detail system design for NHC's business created a configuration of the Javelina system that was incapable of meeting the business requirements of NHC and contributed significantly to NHC's demise. UHH was responsible for the selection of the Javelina system and in Exhibit A Schedule of Services of the Administrative Services Agreement UHH contractually promised to "7. Operate computer systems necessary for its performance of its duties and obligations …."
17. UHH did not perform "…consistent with industry-recognized standards." In my judgment, UHH's failure to meet its industry-recognized and contractual obligations under the terms of the TPA agreement and other agreements with NHC, was a primary factor in NHC's demise.
18. The failure of the NHC's Management Defendants including certain members of the Board of Directors, irrespective of their status as employees of UHH on loan to NHC, to properly select a TPA, supervise the activities of UHH, operate independently from UHH, manage the business of NHC reasonably, and act within the bounds of standard industry practices as required by Section 2.1 of the Administrative Services Agreement were a material breaches of each individual's fiduciary responsibility to NHC.

Osowski's reliance on his understanding of industry standards to support his opinions is misguided. The industry standards Osowski refers to are based on his experience in working in the typical commercial, Medicare Advantage and Medicaid managed care environments. Osowski ignores key aspects of NHC's activities that make it unique. For example, the CO-OP program was a new concept that was initially dependent on Federal funding. Although there were a handful of CO-OPs that previously existed, their start-ups were not based on Federal funding and were not governed by the requirements of the ACA and its associated regulations. NHC was one of a group of 23 organizations that were entering an environment for which there was little, if any, precedent. Furthermore, NHC and the other 22 CO-OPs did not have the benefit of affiliation with an established insurer as do most Medicare Advantage and Medicaid managed care plans. Not only were the CO-OPs required to start up on their own, they had to complete their start-up activities in a very limited time frame. When Osowski cites industry standards, he makes no accommodations for the uniqueness of NHC and the Federal CO-OP program. When Osowski indicates that UHH failed to meet industry standards, he ignores a critically important point. CMS, the Federal agency that funded and regulated NHC, reviewed and approved all of NHC's and UHH's actions and activities that Osowski now opines failed to meet industry standards. As discussed, NHC had to report to CMS on each of its activities and did so, in detail and in accordance with milestones agreed to by CMS. CMS's funding was based on the completion of milestones. NHC and UHH met CMS' requirements. The "industry standards" to which Osowski refers are not subject to Federal oversight, i.e., CMS' requirements. Osowski is comparing the proverbial apples to oranges.

Osowski concentrates on UHH as the cause of NHC's failure and ignores the myriad of vendors used by NHC. Osowski completely fails to consider the significant problems caused by Xerox and the State Exchange as well as other vendors that affected NHC operations. Instead, he opines that "UHH's failure to meet its industry-recognized and contractual obligations under the terms of the TPA agreement and

other agreements with NHC, was a primary factor in NHC's demise."[259] As discussed, problems with the State Exchange and Xerox that led to Xerox's contract being terminated are well documented both publicly and in the record, yet Osowski fails to consider them. Osowski attributes no damages to either Xerox's or the State Exchange's failures and deficiencies.

In his discussion of claims processing, Osowski does not adequately consider that UHH was not the only entity that provided claims processing services to NHC. In fact, UHH did not even perform the majority of claims processing services. Other entities, including NHC, itself, Eldorado, Catamaran, First Health and WellHealth all processed NHC claims.

Osowski completely ignores many of NHC's vendors who also faced implementation challenges and caused NHC to incur budget overruns. Minutes of NHC's Board of Directors clearly illustrate this finding:

- For March 2014, there were two administrative expenses that were "out of budget categories." "Actuarial is over budget" and for UHH there was a carryover charge from the prior month. But, NHC finished under the budgeted deficit amount which was favorable for March 2014.[260]
- For April 2014, the broker commissions were higher than expected and the actuarial expenses were over budget, the customer service/enrollment fees were over budget and found that a $23,000 on-going depreciation amount that wasn't budgeted will re-occur each month.[261]
- As of May 2014, the "broker commission category is out of budget and will remain out of budget for the year." Actuarial expenses were over budget and the temporary help category was over budget due to the need for "assistance in the areas of enrollment data entry and healthcare delivery." UHH was out of budget and consultant and contractor expenses were over budget. "IT expenses for the month are out of budget due to annual computer and internet license renewals" and network access fees from First Health were over budget."[262]
- In June 2014, broker commissions remained over budget, actuarial expenses were over budget, UHH was over budget, enrollment/customer service was over budget for InsureMonkey, and legal fees were over budget.[263]
- For July 2014, broker commissions remained over budget, enrollment/customer service was higher than projected and would remain over budget through the end of the year, UHH was over budget, ongoing depreciation was over budget, and media expense was out of budget.[264]

[259] Osowski Report II, p. 9.
[260] NHC Board of Directors Minutes for May 23, 2014. LARSON014384-LARSON014390 at 014385-86.
[261] NHC Board of Directors Minutes for June 24, 2014. LARSON014391-LARSON014396 at 014392.
[262] NHC Board of Directors Minutes for August 7, 2014. LARSON014397-LARSON014402 at 014398-014399.
[263] NHC Board of Directors Minutes for August 26, 2014. LARSON014403-LARSON014409 at 014404.
[264] NHC Board of Directors Minutes for on September 30, 2014. LARSON014410-LARSON014413 at 014411.

- In September 2014 administrative costs were higher than budget due to "1) higher than expected broker participation with commissions at 10 percent, 2) increased compensation and 3) benefits expenses due to the need for additional staffing, 4) higher than expected IT expenses due to the shift to the Federal Exchange.[265]

It should be noted that 2014 general administrative expenses, which are exclusive of claims adjudication and cost containment expenses, totaled $19 million which exceeded the total start-up loan amount.[266] The largest administrative expenses other than salary and wages were for Enrollment/Premium/CS Ongoing ($3.9 million) and Broker Commissions ($1.7 million).[267]

TPA licensure issues are a red herring. Osowski repeats the SDR's claim that UHH's lack of a TPA license affected its performance as it sought to meet NHC's needs. The lack of a license is not related to performance. It is noteworthy that the penalty for failure to obtain a TPA license in Nevada is an administrative fine of not more than $1,000.[268] As in most of the allegations brought by the Receiver, no effort is made to identify how UHH's lack of a TPA license caused damages to NHC. In fact, whether or not UHH had a TPA license has no impact on NHC or any alleged damages.

Instead, the important issue is whether UHH's performance of TPA services were proper under the circumstances (and CMS' requirements). UHH was successful in performing TPA functions for many years prior to the formation of NHC. In addition, as discussed, CMS approved NHC's use of UHH as a TPA. When relevant data are examined, Osowski's opinion that UHH was incompetent is not based on the facts and has not been proven. Osowski apparently bases his opinion, at least in part, on UHH's supposed processing of claims outside of eligibility and making overpayments to providers. As shown in Section 9 of this report and addressed in detail in the CCI Report, the basis of his opinion is incorrect. Like the SDR, Osowski holds UHH responsible for paying claims outside of eligibility when the eligibility data that was needed by UHH was solely the responsibility of NHC and/or was unreliable. Osowski also, as noted, ignores other vendors that failed to meet their obligations (e.g., Xerox and the State Exchange) and who were actually responsible for the problems that Osowski attributes to UHH.

Osowski opines that the failure of NHC was due to UHH's faulty claims processing, but the claims that he and the SDR assert were processed incorrectly is a small fraction of all of the claims that were processed. The SDR's allegations that most of the claims in question were incorrectly processed are unproven (See Section 9 of this report). In this context, Osowski's theory of causation and liability that UHH was negligent as a vendor and that any and all alleged damages should be associated with UHH has no foundation.

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[265] NHC Board of Directors Minutes for November 25, 2015. LARSON014417-LARSON014421 at 014419-20.
[266] 2014 Annual Statement of the Nevada Health CO-OP to the Insurance Department of the State of Nevada. PLAINTIFF01461315-01461404.
[267] Trial Balance for NHC as of December 31, 2014. PLAINTIFF00007705.xlsx. 2014 Annual Statement of the Nevada Health CO-OP to the Insurance Department of the State of Nevada. PLAINTIFF01461315-01461404.
[268] "Chapter 683A – Persons Involved in Sale or Administration of Insurance". NRS 683A.090. Available at https://www.leg.state.nv.us/nrs/NRS-683A.html#NRS683ASec090.

For service dates in 2014 and 2015, the Javelina claims data[269] shows that 244,342 non-zero paid medical claims (totaling $93.0 million) were processed and paid. I have analyzed the claims for which the SDR asserts damages and find that only 5,686 (2 percent of 244,273) claims and $2.1 million (2 percent of $93.0 million) are even potentially subject to dispute.[270] Table 6 summarizes the paid medical claims incurred in 2014 and 2015 by NHC.

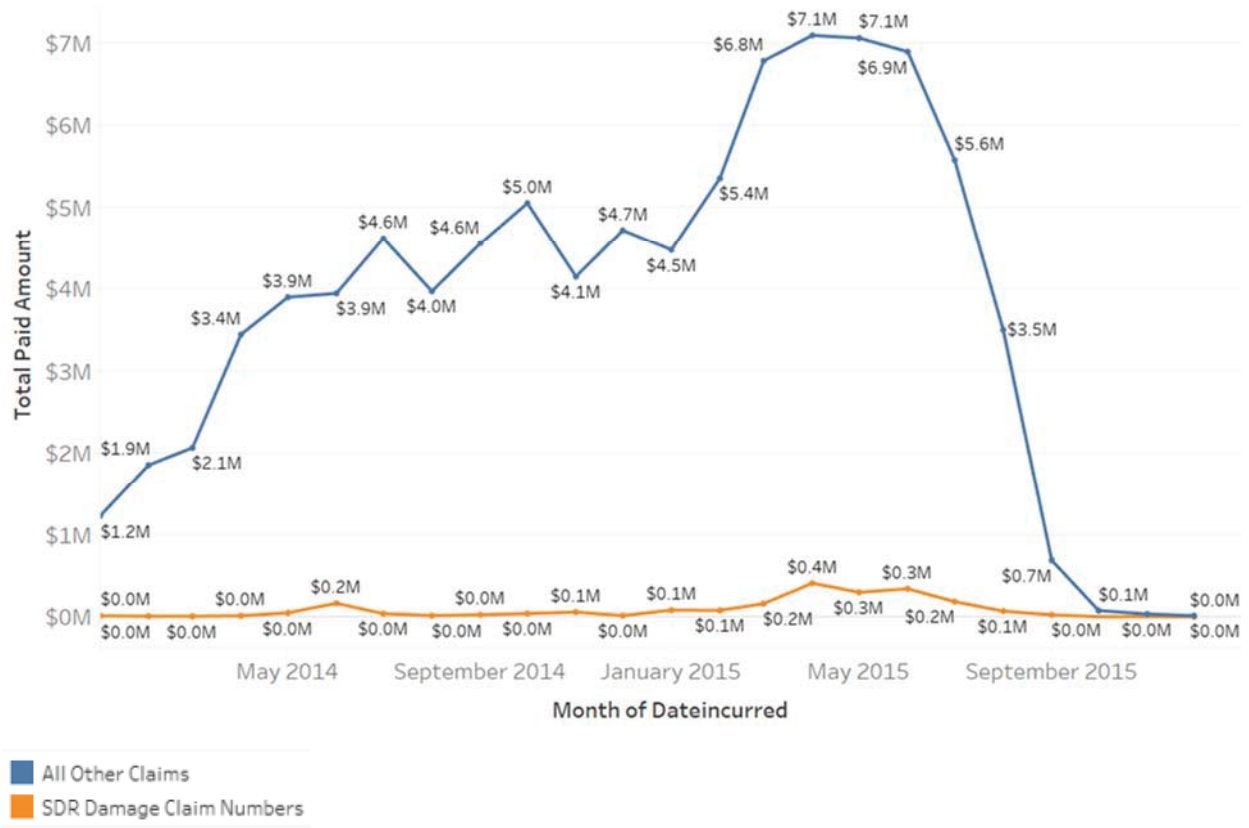
Table 6
SDR Damage Claim Numbers vs. All Other Claims (Paid Medical Claims Incurred in 2014 and 2015)[271]

		# of Claims	% of All Claims	Total Paid Amount	% of Total Paid
2014	All Other Claims	103,582	42.40%	$43,473,776	46.72%
	SDR Damage Claim Numbers*	677	0.28%	$422,873	0.45%
	Total	104,259	42.68%	$43,896,650	47.18%
2015	All Other Claims	135,005	55.27%	$47,521,486	51.07%
	SDR Damage Claim Numbers*	5,009	2.05%	$1,630,178	1.75%
	Total	140,014	57.32%	$49,151,665	52.82%
Overall	All Other Claims	238,587	97.67%	$90,995,263	97.79%
	SDR Damage Claim Numbers*	5,686	2.33%	$2,053,052	2.21%
	Total	**244,273**	**100.00%**	**$93,048,314**	**100.00%**

The small fraction of claims that Osowski asserts were incorrectly processed nullifies his opinion that these claims were an "essential part of the explanation for NHC's hazardous financial condition.[272]" To illustrate how small a fraction these allegedly incorrectly processed claims were to the overall claims volume of NHC, I have summarized these claims by the month in which they were incurred for health plan years 2014 and 2015[273] below.

[269] Table: *AdjudicationResult of* SDR Javelina SQL Backup File. PLAINTIFF02484563.
[270] The SDR asserts that claims were paid outside of eligibility for members that are shown as eligible in the SDR's Javelina SQL backup (PLAINTIFF02484563). I have excluded these claims in this analysis. I understand that NHC was operating under "presumed eligibility" and therefore any potential damages may be overstated. See NHC Board of Directors Minutes for January 22, 2014. LARSON014362-LARSON014366; and NHC Board of Directors Minutes for April 29, 2014. LARSON014377-LARSON014383.
[271] Calculated using the *AdjudicationResult* table from the SDR's Javelina SQL backup (PLAINTIFF02484563) for claims incurred in 2014 and 2015, having a *BenefitPlanName* other than "Rx Plan" (exclude Rx claims) and *Claimstatus* "PAID" and a non-zero value for *TotProvPaid*. Claims costs were calculated using the *TotProvPaid* field. I removed the alleged paid outside of eligibility damage claims that I found to be eligible in the SDR's Javelina SQL backup (PLAINTIFF02484563). The $2.05 million of claims include alleged damages from payments for claims paid outside eligibility in 2015, which the SDR attributes to InsureMonkey. Without explanation, Mr. Fish has now attributed these damages to UHH. Therefore, the alleged SDR damage claims in the table above are likely overstated.
[272] DRAFT SDR Report, p. 4. PLAINTIFF02479813-02479851 at 0247916.
[273] Calculated using the *AdjudicationResult* table from the SDR's Javelina SQL backup (PLAINTIFF02484563) for claims incurred in 2014 and 2015, having a *BenefitPlanName* other than "RX Plan" (exclude Rx claims) and *Claimstatus* "PAID" and a non-zero value for *TotProvPaid*. Claims costs were calculated using the *TotProvPaid* field.

Figure 1
SDR Damage Claim Numbers vs. All Other Claims (Paid Medical Claims Incurred in 2014 and 2015)



The above figure illustrates how the allegedly incorrectly processed claims make up only a small fraction of all claims processed, even when viewed on a monthly basis.

Osowski fails to demonstrate that UHH was responsible for creating a backlog of unprocessed and unpaid claims. Osowski (as well as Fish and the SDR) opine that UHH was responsible for "meaningful delays in the timely processing of claims"[274] and that UHH was in breach of the NHC-UHH Administrative Services Agreement due to the claim backlog and related claim aging reports.[275] Osowski asserts his opinion without actually performing any analysis regarding the causes of the backlog, who or what was responsible for the backlog, and what relative contributions these causes might have played on the overall backlog. Instead, he declares that UHH is solely responsible for the backlog. In fact, many other

I corrected for the claims that I found to be eligible when I examined the claims alleged to be paid outside eligibility. The $2.05 million of potentially damaged claims include alleged damages from payments for claims paid outside eligibility in 2015, which the SDR attributes to InsureMonkey. Without explanation, Mr. Fish has now attributed these damages to UHH. Therefore, the potentially damaged claims in the table above are likely overstated.

[274] DRAFT SDR Report, p. 12. PLAINTIFF02479813-02479851 at 0247924.

[275] DRAFT SDR Report, p. 14. PLAINTIFF02479813-02479851 at 0247926.

contributing factors outside of UHH's responsibility contributed to the backlog as discussed in this section and in the CCI Report.
Osowski relies on the SDR's analysis of claims backlog which fails to address all of the causes of the backlog, (which are well documented in the work papers that the DRAFT SDR Report cites for its backlog statistics). For example, the SDR cites to the NHC Board Minutes from February 19, 2014:

> "Even by February 19, 2014, the CO-OP had received 2,800 claims, but had only processed and paid 42, a total of just $8,000."[276]

The SDR fails to mention any of the critical factors that contributed to the claims backlog, factors which are addressed in the same NHC Board minutes document. One significant factor driving difficulties with claims processing, which was outside of UHH's responsibilities as TPA, was the on-going issues and challenges NHC was experiencing with the State Exchange and Xerox.[277] Highlights from the NHC Board minutes the DRAFT SDR Report fails to mention include:

- NHC was speaking regularly with the Nevada State Governor and other carriers regarding the challenges with data submissions from Xerox to NHC.
- The 3,000 new members that NHC has not received any information on from Xerox due to the State Exchange's on-going data transfer failures.
- The letter prepared by NHC attorneys to Xerox and the Nevada State Governor outlining problems NHC was having with the State Exchange and Xerox.
- How Xerox has and continues to hurt NHC's credibility in the market place and injured NHC members.
- An example of a New Year's Eve heart attack patient being left with a $410,000 bill and unmanaged care due to Xerox failing to inform NHC that the patient was an NHC member.
- The fact that, over 82 percent of the 2,800 claims (2,300 claims) were paper claims.[278]

The DRAFT SDR Report's next set of citations continues to ignore multiple pages that describe Board discussions regarding difficulties NHC was having with Xerox and the State Exchange, along with other key factors driving the claims backlog. The DRAFT SDR Report cites the May 23, 2014, NHC Board minutes[279] stating that by this date claims pending adjudication had reached 5,500.[280] However, the SDR fails to mention the continued difficulties with Xerox and the State Exchange and how they were adversely affecting NHC and its ability to process claims. Below are key issues ignored by the SDR and Osowski:

- Xerox, finally admitting their payment collection process is only working at 45 percent capacity.

[276] DRAFT SDR Report, p. 12. PLAINTIFF02479813-02479851 at 0247924.
[277] NHC Board of Directors Minutes for February 19, 2014. LARSON014367-LARSON014370 at 014368.
[278] See PLAINTIFF00388225-229 at 00388225 ("Plum admits expectations were that 80 percent would be electronic and 'opposite is true'").
[279] NHC Board of Directors Minutes for May 23, 2014. LARSON014384-LARSON014390 at 014386.
[280] DRAFT SDR Report, p. 12. PLAINTIFF02479813-02479851 at 0247924.

- The possible extension of payment deadlines for consumers past May 30th since 4,000 consumers wanted to pay their premiums but were unable to, because of Xerox system errors.
- Xerox presenting NHC with a report of 900 delinquent members dated back to January 2014 that was never reported and of which NHC and UHH were unaware.
- The overall, and undeniable, negative impact Xerox and the State Exchange had on NHC's finances. Fifty percent of resources had been committed to Xerox and Xerox related issues since October 2013.

Osowski not only fails to establish that the claim backlog was caused by UHH, but he fails to establish what a normal or expected level of claim backlog would be for a newly created health insurance company, with newly implemented systems, such as NHC. In fact, the U.S. Senate Report, titled *Failure of the Affordable Care Act Health Insurance CO-OPs*, dated March 10, 2016, identifies the challenges all ACA CO-OPs were experiencing. In particular, the report describes the CO-OPs' struggle to hire staff and to build their technological systems.[281]

Although Osowski makes references to claim backlog numbers from the NHC Board minutes referencing issues with the Javelina system such as "glitches with the functionality of the Javelina system that has held back auto adjudication of claims"[282], he fails to establish that these backlogs or technological challenges were unique to NHC. In fact, it is well-documented that similar challenges were experienced by other CO-OPs, as described in the U.S. Senate report.

Furthermore, the email correspondence between NHC's CEO and UHH's COO highlights the need for more staff and the significant frustration surrounding the claim backlog due to actions and business decisions made by NHC (not UHH).[283] This email from UHH's COO describes NHC's decisions and actions and how these decisions directly impacted the claim backlog. Issues identified by UHH's COO regarding NHC actions that were driving the claim backlog include:

- Retroactive contracts;
- Inconsistent direction;
- 40-letter agreements requiring manual processing;
- Hundreds of CRM requests from NHC to UHH staff; and
- Information is unclear and not timely.

[281] U.S. Government Publishing Office. "Review of the Affordable Care Act Health Insurance Co-Op Program: Hearing Before the Permanent Subcommittee on Investigations of the Committee on Homeland Security and Governmental Affairs", United States Senate, One Hundred Fourteenth Congress, Second Session, dated March 10, 2016, p. 16.
[282] DRAFT SDR Report, p. 12. PLAINTIFF02479813-02479851 at 0247924.
[283] Email from Dolores Michael, Chief Operating Officer of UHH, and Tom Zumtobel, Chief Executive Officer of NHC, Regarding September Inventory Report, dated September 23, 2014. PLAINTIFF00869027-00869029.

The full email from UHH's COO is below[284]:

From: Michael, Dolores [DMICHAEL@UNITEHEREHEALTH.ORG]
Sent: 9/23/2014 8:56:01 AM
To: Tom Zumtobel [tzumtobel@nevadahealthcoop.org]
Subject: September Inventory report
Attachments: image007.jpg; image008.png; image009.png; image010.png; image011.png; image012.png; image013.png; image014.jpg; image015.gif; image016.png; image017.png; image018.png; image019.png

Importance: High

Tom,

I know you and Mike will be talking about what is driving up the inventory, however, I feel the need to make sure that you are aware of our significant frustration with the inventory as well. There are so many adjustments that continue to distract from normal processing. I hope your staff is keeping you in the loop about the issues that take away from processing time. Some of the things that are frustrating from our end are:

- Retroactive contracts – We just completed over 600 adjustments associated with Desert Radiology that needed to be done due to retro contract issues. There is also a new retroactive Chiro contract that will cause adjustments. Any retroactive contract generally cause adjustments to claims. We get pressured to make these adjustments from CO-OP staff.
- There seems to be inconsistency in direction we have been given regarding processing Comprehensive Cancer Center claims that will cause manual intervention
- There are over 40 Letter Agreements (LOAs) that require special manual processing
- Reinsurance requires a lot of communication and staff engagement.
- We have recently completed responses on hundreds of CRMs – requests from your staff to review claims mostly to identify status or to validate if a claim was processed correctly that turn out to be correct

We cannot keep up our normal processing and handle all of these manual interventions without more staff. Furthermore, we are already late in getting the 2015 Plan Building work done. We need information from the CO-OP to move this forward. Also, we have asked Pam and Basil for additional staffing which we should have hired by now in order to be properly trained. As we talked a couple of weeks ago, the alternative is for you to hire the staff and help move this work forward.

It becomes very frustrating to us when we can't process claims efficiently due to these continued adjustments, or when manual work takes over streamlined processing and when information is unclear or not given to us timely. This highlights the reason why it is important for your staff to get more familiar with how to process claims as quickly as possible. I will be happy to discuss this with you at your convenience.

Dolores Michael
Chief Operating Officer

As discussed by UHH's COO (Dolores Michael), there were many other contributing factors to the claims backlog, many of which were outside of UHH's responsibility or were issues expected with a start-up business that is implementing new computer systems, such as a claims processing system. Osowski incorrectly asserts the backlog was caused by UHH without performing any analysis as to the backlog's actual causes. Improperly, Osowski simply assumes UHH is responsible for the backlog without providing any evidence.

9. Analysis of Plaintiff's Experts' Damages Reports

Plaintiff's experts rely heavily on work completed by the SDR and submitted in the report entitled: Special Deputy Receiver's Report for Nevada Health CO-OP, Causation and Damages for Key Vendors

[284] Email from Dolores Michael, Chief Operating Officer of UHH, and Tom Zumtobel, Chief Executive Officer of NHC, Regarding September Inventory Report, dated September 23, 2014. PLAINTIFF00869027-00869029 at 00869022.

Unite Here Health, Nevada Health Solutions, and InsureMonkey.[285] In this section, the reports prepared by the SDR and Mark Fish (Fish) are addressed.[286]
In my summary of opinions, which was presented earlier in this report, I indicated that Receiver's experts' opinions on damages were seriously flawed. I provide a detailed analysis of these flaws in this section of my report. Because Fish's and Osowski's analyses are dependent on the DRAFT SDR Report, I discuss significant flaws in key components of the SDR's analysis prior to addressing Fish's and Osowski's reports. Three important points, however, must be addressed before describing the flaws in the SDR's report.

First, in my experience, damages are attributed to a defendant because a plaintiff was injured by the defendant's actions. In this case, the injury experienced by NHC is its failure or demise, but neither Fish nor Osowski demonstrate or otherwise offer any evidence that UHH and/or NHS were substantial factors causing this failure. Instead of trying to establish a causal link between the actions of UHH and/or NHS and the failure of NHC, Fish and Osowski identify only problems and issues that they speculate are related to UHH and NHS activities. Although they fail to provide evidence that these alleged activities caused or were a substantial factor in bringing about NHC's failure, they identify amounts related to these activities that they incorrectly refer to as damages.

Second, neither Fish nor Osowski account for the actions of either (i) other vendor defendants namely Milliman, Millennium, InsureMonkey, or Larson, or (ii) other vendors that provided services to NHC, namely the Nevada State Exchange or Xerox. None of the Receiver's Experts acknowledge or even consider that the SDR has multiple overlapping claims and pending actions against various NHC vendors with the potential to result in a double recovery of damages if not properly accounted for. I am aware of the following:

- The SDR's complaint against WellHealth, Medsource and various individual defendants;[287] the SDR claimed damages under various theories such as failure to become a state approved TPA, breach of fiduciary duty, and failure to perform to industry standards. But, most importantly the SDR asserts that, "WellHealth was unable to keep up with claims processing and certain providers were not receiving payments on time, resulting in financial losses, financial misreporting, improper setting of rates, loss of federal receivables, and further draw downs on CMS loans by NHC." These claims are substantially similar to claims against UHH and/or NHS yet Fish and Osowski fail to recognize or account for a potential double recovery of damages.

[285] DRAFT SDR Report. PLAINTIFF02479813-02479851.
[286] I do not directly address the DeVito Report.
[287] Complaint. State of Nevada, Ex Rel. Commissioner of Insurance, Barbara D. Richardson v. WellHealth Medical Associates (Volker), PLLC, et al. Case No. A-20-818118-C.

- The court granted defendant Milliman, Inc.'s motion to compel arbitration.[288] Milliman performed actuarial and consulting services for NHC. Fish opines that the performance of actuarial and consulting services is directly related to Avoidable Costs of Additional Losses:[289]

> In my opinion, had NHC accurately recorded the IBNR reserve, recognized a PDR, and booked the Catamaran payable in their NAIC annual statement filing to the Nevada DOI, the resulting impact to statutory surplus and RBC would have triggered regulatory action. Consequently, NHC would have recognized its insolvency sooner, forcing the wind-down and closure of insurance operations sooner, and avoiding additional losses incurred throughout 2015.

  Therefore, it is unclear which and to what extent the different vendors are allegedly responsible for $72,700,000 in damages for Avoidable Costs of Additional Losses. Fish has failed to recognize or account for a potential double recovery of damages.
- The SDR asserts that "Millennium failed in its responsibilities which included, without limitation, ensuring that statutory accounting and reporting principles had been followed, and its work resulted in financial misreporting to the Nevada DOI, and the prolongation of NHC's business at great loss beyond the point at which NHC's operations would have been halted but for Defendant Millennium's acts and conduct."[290] Fish fails to address the fact that the SDR settled these claims, claims that are similar to claims made against UHH, with Millennium for $162,500,[291] but Fish attributes Avoidable Costs of Additional Losses to UHH in the amount of $72,700,000 under the same theory.
- As alleged by the SDR, "Larson served as NHC's independent auditor that, among other issues, performed deficient audits, failed to adequately inspect and value reserves and receivables, failed to properly disclose related party transactions, and failed to disclose the existence of substantial doubts about NHC's inability to continue as a going concern."[292] Fish opines that the performance of auditing services is directly related to Avoidable Costs of Additional Losses:[293]:

> In my opinion, had NHC accurately recorded the IBNR reserve, recognized a PDR, and booked the Catamaran payable in their NAIC annual statement filing to the Nevada DOI, the resulting impact to statutory surplus and RBC would have triggered regulatory action. Consequently, NHC would have recognized its insolvency sooner, forcing the wind-down and closure of insurance operations sooner, and avoiding additional losses incurred throughout 2015.

[288] Notice of Entry of Order Granting Milliman's Motion to Compel Arbitration. State of Nevada, Ex Rel. Commissioner of Insurance, Barbara D. Richardson v. Milliman, Inc. et al. (March 12, 2018). Case No: A-17-760558-B.
[289] Fish Report II, p. 18.
[290] Amended Complaint. State of Nevada, Ex Rel. v Milliman, Inc., et al. (September 24, 2018). ¶ 23.
[291] State of Nevada, Ex Rel. Commissioner of Insurance, Barbara D. Richardson, In Her Official Capacity as Receiver for Nevada Health CO-OP v. Milliman, Inc. et al. Eighth Judicial District Court. Clark County, Nevada. Case No.: A-17-760558-C. Joint Motion for Determination of Good Faith Settlement by Plaintiff and Defendant Millennium Consulting Services, LLC on Order Shortening Time.
[292] Amended Complaint. State of Nevada, Ex Rel. v Milliman, Inc., et al. (September 24, 2018). ¶ 24.
[293] Fish report II, p. 18.

> In my opinion, insolvency, a loan default, loss of CMS funding, or a calling of the CMS loans due, which was inevitable due to a loan default, would have been the end of NHC as a viable organization, certainly when NHC filed its annual statement on February 27, 2015, or the latest by March 31, 2015, when Larson should have recognized NHC's financial issues.[62]

Therefore, it is unclear which and to what extent various vendors are allegedly responsible for $72,700,000 in damages for Avoidable Costs of Additional Losses. Fish has failed to recognize or account for a potential double recovery of damages.

- Most telling, however, is that the SDR is alleging the **exact** same amount of damages in a complaint against the Silver State Insurance Exchange that Fish and Osowski are attributing to UHH, "Defendant has retained five hundred ten thousand six hundred fifty-one dollars and twenty-seven cents ($510,651.27) of premiums paid by Nevada citizens for purchase of health care insurance plans from NHC (the 'Retained Premiums')".[294] The Receiver is attempting to obtain a double recovery for the same alleged injury. This clearly illustrates that Fish and Osowski have done no independent calculations or analysis of damages and are relying solely on the SDR work product to claim damages with no causal link. In reference to the SDR's claimed damages, the Silver State Health Insurance Exchange came to the same conclusion, "the SDR's own contractor, Red River Consulting was unable to corroborate the spreadsheet figures as presenting an accurate picture of liability…."[295]

The SDR's Complaint against the Silver State Insurance Exchange includes:[296]

> 24. Defendant has retained five hundred ten thousand six hundred fifty-one dollars and twenty-seven cents ($510,651.27) of premiums paid by Nevada citizens for purchase of health care insurance plans from NHC (the "Retained Premiums").

The Fish Report II includes:[297]

> 6. Damages for Uncollected Premiums from the Nevada State HIE: $510,651.27[81]
>
> UHH under collected premium payments from the HIE totaling $510,651.27 in 2014.

The Osowski Report II includes:[298]

[294] Complaint. State of Nevada, Ex. Rel. Commissioner of Insurance, Barbara D. Richardson v. Silver State Health Insurance (June 5, 2020). Case No: A-20-816161- C.
[295] Letter from Heather Korbulic, Executive Director of Silver State Health Insurance Exchange, to Mark Bennett, Special Deputy Receiver of Nevada Health CO-OP, Regarding Nevada Health CO-OP ("NHC"); Demand for Payment of Underpaid Premium Amounts to NHC: Your File No. 70750-000, dated April 17, 2019. PLAINTIFF02499352-02499353 at PLAINTIFF02499352.
[296] Complaint. State of Nevada, Ex. Rel. Commissioner of Insurance, Barbara D. Richardson v. Silver State Health Insurance (June 5, 2020). Case No: A-20-816161- C
[297] Fish Report II, p. 32.
[298] Osowski Report II, p. 73.

6. Damages for Uncollected Premiums from the Nevada State HIE: $510,651.27

   UHH is responsible for under collected premium payments from the HIE totaling $510,651.27 in 2014 by not setting up proper data systems to maintain and track NHC enrollment files, including no setup of a proper data system for the reconciliation of membership enrollment with the HIE.

Third, to address the "damages" identified by Fish and Osowski in their February 2020 reports, they must be itemized. Table 7 presents an itemized list of these damages.

Table 7
Damages Identified by the SDR and Adopted by Fish and Osowski in Their February 2020 Reports

Description	Source	Amount
2014-2015 Claims Paid Outside of Eligibility	SDR	$9,343,352
2014-2015 Overpayment of Claims	SDR	$1,163,852
2014-2015 Duplicate Claims Payments	SDR	$133,889
Loss of Federal Receivables	SDR	$6,175,483
Uncollected Premiums from State Exchange	SDR	$510,651
Utilization Management Damages	Fish	$1,160,000
Damages for All Amounts Paid to UHH	SDR	$7,686,382
Avoidable Costs of Additional Losses	Fish	$72,700,000
Damages Due to Premature Commencement of Operations	SDR/DeVito	$142,441,000

Seven of the nine categories listed in Table 7 are addressed in this report. These categories are:

- 2014-2015 Claims Paid Outside of Eligibility,
- 2014-2015 Overpayment of Claims,
- 2014-2015 Duplicate Claims Payments,
- Loss of Federal Receivables,
- Uncollected Premiums from State Exchange, and
- Utilization Management Damages.
- Avoidable Costs of Additional Losses

Three categories are primarily addressed in a report prepared by another expert (Xavier Oustalniol[299]). These categories are:

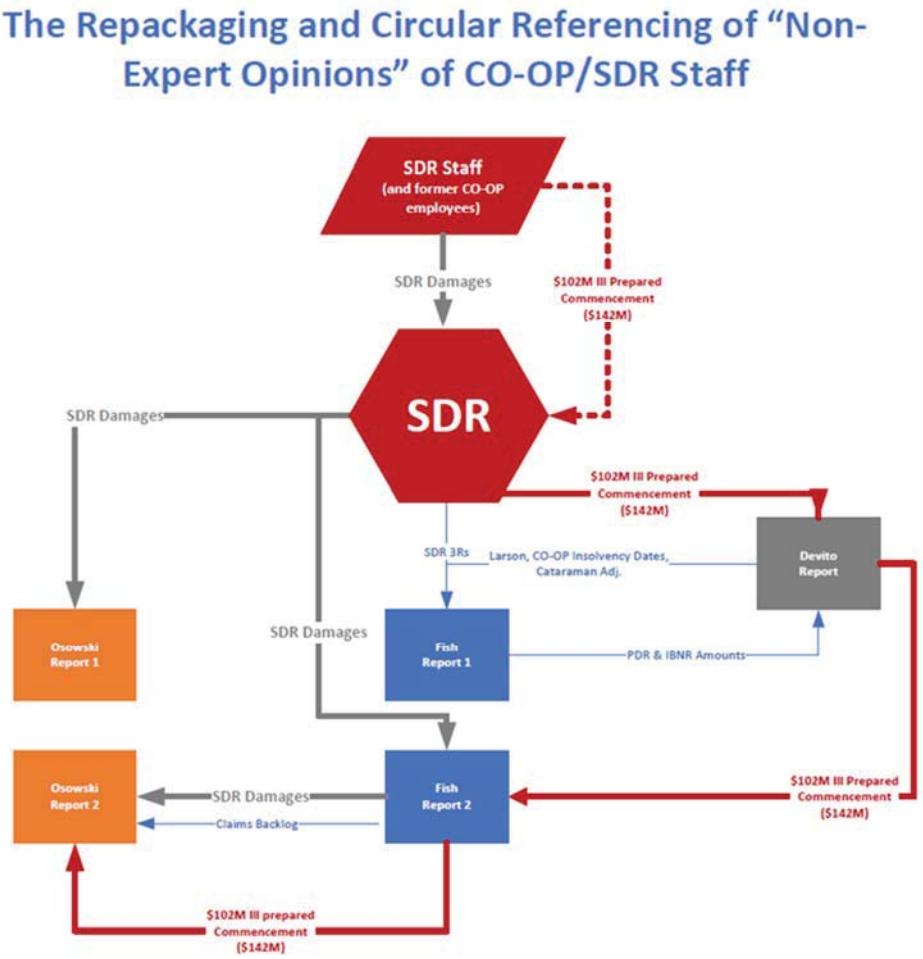
- Damages for All Amounts Paid to UHH,
- Avoidable Costs of Additional Losses, and
- Damages Due to Premature Commencement of Operations.

In addition, Mr. Oustalniol also addresses the loss of Federal receivables.

[299] Expert Report of Xavier Oustalniol, StoneTurn, LLC dated October 2, 2020 (Oustalniol Report)

9.1 The SDR's Calculation of Damages is Substantially Flawed

The SDR submitted a draft report that has yet to be updated. Although the DRAFT SDR Report is a draft, it is important to review because, in most instances, Fish and Osowski adopt the SDR's damage calculations rather than doing their own calculations. As reflected in the diagram below, substantially all of Fish and Osowski's damages, other than interest, were calculated by the SDR.[300]



It should be noted that the four reports prepared by Mr. Fish[301] and Mr. Osowski[302] flip-flop on who believes the DRAFT SDR Report's damages appear reasonable. On July 30, 2019, the original Fish Report was silent on the SDR Damages, and it was the original Osowski Report that asserted the DRAFT SDR

[300] Michael Katigbak (Controller for NHC), "has not been specially retained…as an expert in this matter" but may "testify regarding damage calculations for NHC." Plaintiff's Twentieth Supplemental Disclosures Pursuant to NRCP 16.1. State of Nevada, Ex Rel. v Milliman, Inc., et al (February 21, 2020). The revised 3 Rs calculations in Table 7 were performed by Indegene. See Fish Report II, p. 23.

[301] Fish Report I and Fish Report II.

[302] Osowski Report I and Osowski Report II.

Report's damages "appear reasonable."[303] Then, in the February 7, 2020 Fish Report which includes the DRAFT SDR Report's damages, Fish also opines that the SDR Damages "appear reasonable based upon the review and due diligence that I have performed."[304] The February 7, 2020 Osowski Report, however, is now silent on the DRAFT SDR Report's damages and merely cites the February 7, 2020 Fish Report as its source of damages.[305] Further, in apparent deference to Fish, Osowski has literally copied and pasted several of the Fish's paragraphs and damage amounts into his report. For example, below are snippets from the two reports showing the verbatim copy and paste:

Fish Report II[306]

1. Damages for Claims Paid Outside of Eligibility: $9,343,351.85[73,74,75]

UHH paid claims for members who were not eligible on the HIE due to the inability to correctly reconcile enrollment information, totaling $5,593,327.73 in 2014. Further, UHH or NHC erroneously paid medical and prescription drug claims payments to ineligible members totaling $3,750,024.12 in 2015, which was again caused by the failure to properly maintain and track NHC enrollment files or properly reconcile membership enrollment with the HIE. As further detailed in Mr. Osowski's report dated February 7, 2020, UHH failed to properly set up an adequate data processing and information technology system for NHC before and after its operations commenced in 2014, which led to claims being paid outside of enrollment and enrollment information not being properly tracked. UHH is responsible for the aforementioned claims paid outside of enrollment for years 2014 and 2015.

Osowski Report II[307]

1. Damages for Claims Paid Outside of Eligibility: $9,343,351.85

UHH paid claims for members who were not eligible on the Health Insurance Exchange (HIE) due to the inability to correctly reconcile enrollment information, totaling $5,593,327.73 in 2014. Further, UHH erroneously paid medical and prescription drug claims payments to ineligible members totaling $3,750,024.12 in 2015, which was again caused by the failure to properly maintain and track NHC enrollment files or properly reconcile membership enrollment with the HIE. UHH failed to properly set up an adequate data processing and information technology system for NHC before and after its operations commenced in 2014, which led to claims being paid outside of enrollment and enrollment information not being properly tracked. UHH is responsible for the aforementioned claims paid outside of enrollment for years 2014 and 2015.

Both Fish's and Osowski's updated reports are silent as to why they flip-flopped on who believes the DRAFT SDR Report's damages appear reasonable. However, both of their updated reports are consistent with their original reports in that they are again completely silent with respect to describing any due diligence or testing they performed to ensure the DRAFT SDR Report's damages are "reasonable." In this report, I show that the DRAFT SDR Report's damage methodologies, calculations, and estimates are deficient and unreliable.

[303] Osowski Report I, p. 44.
[304] Fish Report II, p.31.
[305] Osowski Report II, p.71.
[306] Fish Report II, p. 31.
[307] Osowski Report II, p.72.

Another deficiency of the February 7, 2020 Fish Report is that it mixes and matches the damage categories of the DRAFT SDR Report between different defendants in the case, contradicting the DRAFT SDR Report itself. For example, the Fish Report claims $9.343 million in damages for claims paid outside of eligibility (POE)[308] for both 2014 and 2015 ($5.593 million for 2014 and $3.75 million for 2015); however, the DRAFT SDR Report attributes only the alleged $5.593 million of 2014 POE damages to UHH, while attributing the $3.75 million of 2015 POE damages to InsureMonkey.

The DRAFT SDR Report clearly states that the 2015 POE damages are associated with InsureMonkey and never even mentions UHH as part of the 2015 POE damages discussion:

> "IM had the responsibility to properly administrate raw enrollment and payment data files necessary for proper recordkeeping of eligibility, coverage status, and claims payment history for CO-OP members.[309]"

> "…to the extent that NHC's enrollment systems contained ambiguous information, and incorrect information were not updated to the most recent eligibility status, that is the result of InsureMonkey's negligence."[310]

> "The payment of claims outside of eligibility, made in reliance on inaccurate, poorly maintained, or ambiguous claims and enrollment data, is IM's responsibility as systems administrator."[311]

Both Fish and Osowski fail to mention the mixing and matching of damages between the different defendants and provide no justification or discussion as to why they contradict the DRAFT SDR Report's findings and conclusions regarding the 2015 POE damages attributable to UHH.

This irreconcilable contradiction between Fish and the DRAFT SDR Report regarding the 2015 POE damages is not surprising given that the Receiver's experts have failed to establish causality on a claim by claim basis. Without a coherent theory of liability for UHH and a detailed, claim-based damage analysis, it is not difficult to see why Fish and (Osowski via the "copy and paste" damages of Fish into his report) contradict the DRAFT SDR Report. This contradiction alone causes the alleged 2015 POE damages associated with UHH to be deficient and therefore unreliable.

Based on my review of the Javelina claims database, the various damage figures in the DRAFT SDR Report appear to have been generated by multiple NHC staff members and contractors, such as accountants, controllers, and claims analysts and were not created by any of the Receiver's damages experts. It appears that these various NHC staff created several ad-hoc schedules for the different SDR damage categories, without apparently considering that the damage categories may overlap between

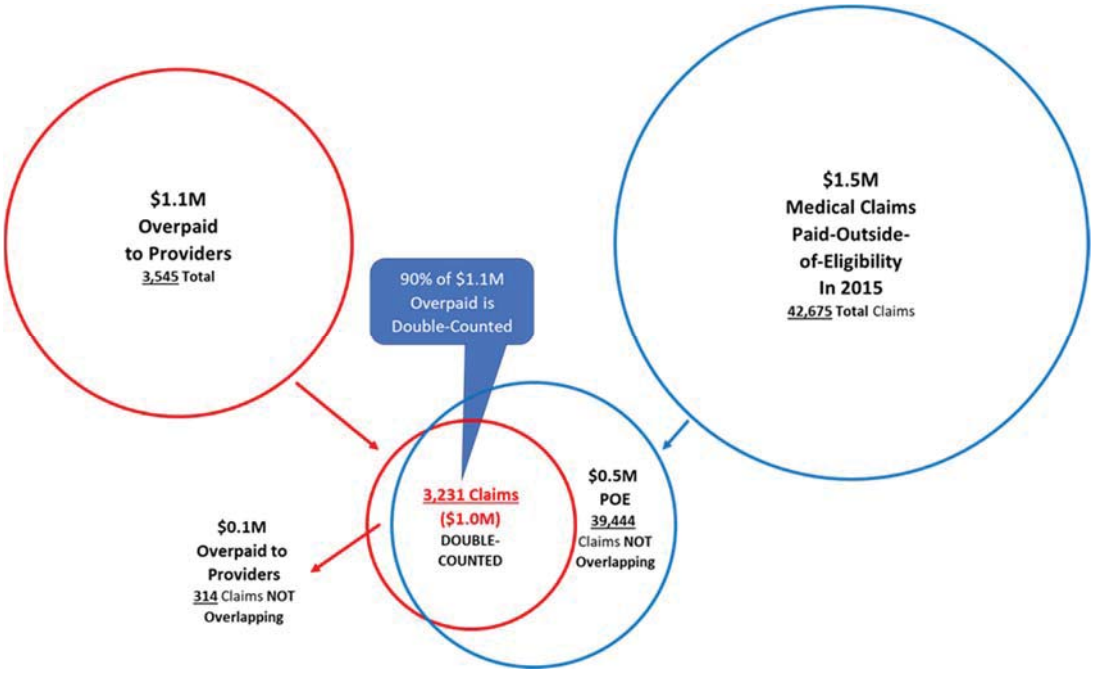
[308] Fish Report II, p. 31.
[309] DRAFT SDR Report, p. 28. PLAINTIFF02479813-02479851 at 02479840.
[310] DRAFT SDR Report, p. 29. PLAINTIFF02479813-02479851 at 02479841.
[311] DRAFT SDR Report, p. 30. PLAINTIFF02479813-02479851 at 02479842.

the different defendants and/or damage categories. While Fish claims to have performed "due diligence[312]" on the damages set forth in the DRAFT SDR Report and that the damages "appear reasonable[313]"; it does not appear that he performed the most basic due diligence of checking whether the SDR's staff double counted damages. Again, the failure of the SDR, Fish, and Osowski to prevent double, or even triple counting of damages renders the SDR's damage amounts to be deficient and therefore unreliable. Further, the copying and pasting of the same damage figures that are in the DRAFT SDR Report into the Fish and Osowski reports[314] clearly renders these two reports' damage amounts to be deficient and therefore unreliable.

For example, the DRAFT SDR Report alleges $3.8 million in damages for claims paid outside of eligibility in 2015[315] of which $1.5 million is for medical claims.[316] The DRAFT SDR Report also alleges $1.1 million in damages for overpayments to providers.[317] The underlying schedules referenced in the DRAFT SDR Report[318] to support these alleged damages appear to have been created or partially created by NHC employees during the SDR's control of the CO-OP.[319] However, they did not investigate or control for the possibility that damage amounts might be overlapping or double-counted with other damage categories or with other defendants. A simple analysis of the claim numbers produced in the SDR working schedules show that over 90 percent[320] of the alleged overpayment to providers[321] are double-counted or overlapping with 2015 medical claims allegedly paid outside of eligibility[322]damage category. A Venn diagram of the double counting is below:

[312] Fish Report II, p.31.
[313] Fish Report II, p. 31.
[314] Osowski Report I and II, Fish Report II.
[315] As discussed in prior paragraphs, these damages are attributable to InsureMonkey by the DRAFT SDR Report, however, they are also irrationally and simultaneously attributable to UHH by Fish.
[316] DRAFT SDR Report, p. 29. PLAINTIFF02479813-02479851 at 02479841.
[317] DRAFT SDR Report, p. 8. PLAINTIFF02479813-02479851 at 02479820.
[318] DRAFT SDR Report, p. 7, FN#7 PLAINTIFF02479813-02479851 at PLAINTIFF02479819.
[319] The column headings in the Excel workbook (PLAINTIFF02479807) make reference to "Mike K" and "Jeff K".
[320] The overlapping dollar amounts for the alleged overpayments to providers not clawed back will not exactly tie out with the dollar amounts for the alleged 2015 medical claims paid outside eligibility because overpayments can be partially damaged, however, a claim paid outside eligibility is considered to be fully damaged.
[321] There appears to be a typo in the Plaintiff work paper PLAINTIFF02479807, worksheet "$1.1 Mil overpayment". The information associated with claim number 215-0000338540-20 actually matches the information for claim number 215-0000338540-02 in the *AdjudicationResult* table of the SDR's Javelina backup. If this error is corrected there will be 313 Not Overlapping Overpaid Claims, 49,443 Not Overlapping POE 2015 Claims and 3,232 Overlapping claims between the two damage categories.
[322] Plaintiffs included Rx claims in their workpaper, even though these are supposed to only be medical claims paid outside eligibility. PLAINTIFF02479920. The number of 2015 medical claims paid outside eligibility is 17,615, of which 14,383 are not overlapping.

Figure 2
SDR Damage Categories Overlap Ninety Percent [323]

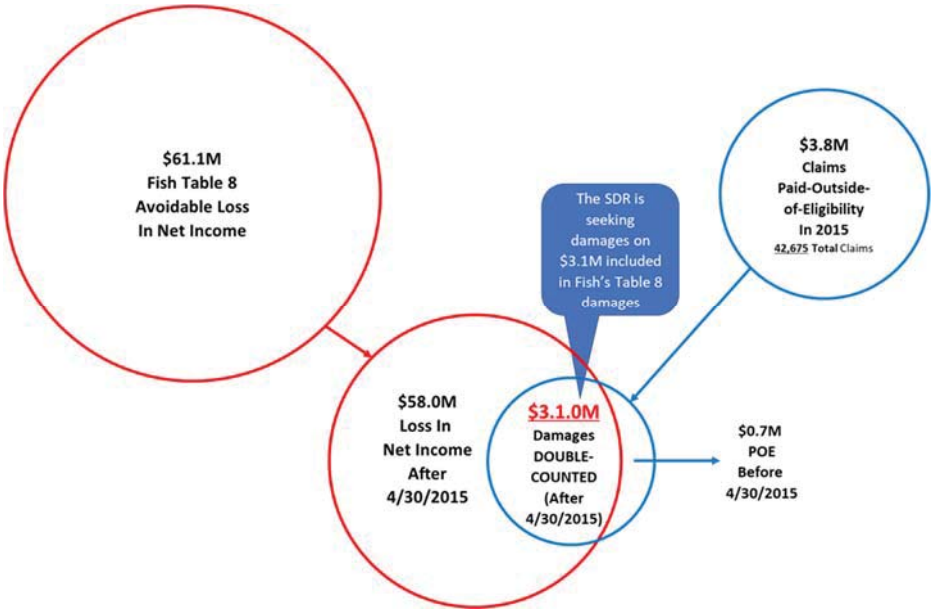


This overlapping or double counting problem is not limited to one or two damage categories but is endemic to the DRAFT SDR Report's fatally flawed damage methodology. There was no attempt by the SDR, the SDR's staff, Fish or Osowski to acknowledge, control or account for overlapping damages. Instead, Fish and Osowski appear to have simply taken the SDR's damage categories at face value and copied and pasted the values into their reports and added the categories together. They appear to be unaware that many of these categories overlap and are being double counted across defendants and damage categories.

For example, Fish also alleges $61.1 million in avoidable loss in net income in his Table 8, but most of the medical claims flowing through Fish's Table 8 damages are included in the 2015 paid outside of eligibility damages and are therefore double (or possibly even triple) counted. In fact, 82 percent of the $3.8 million of 2015 paid outside of eligibility damages are double counted in Fish's Table 8 damages as illustrated by the Venn diagram below:

[323] The Venn diagram was created by comparing the list of damaged claim numbers from the SDR's working papers on 2015 medical claims paid outside eligibility (PLAINTIFF02479920) and on claims with overpayments to providers (PLAINTIFF02479807).

Figure 3
Eighty Percent of SDR Damage 2015 Paid Outside of Eligibility Overlap[324]



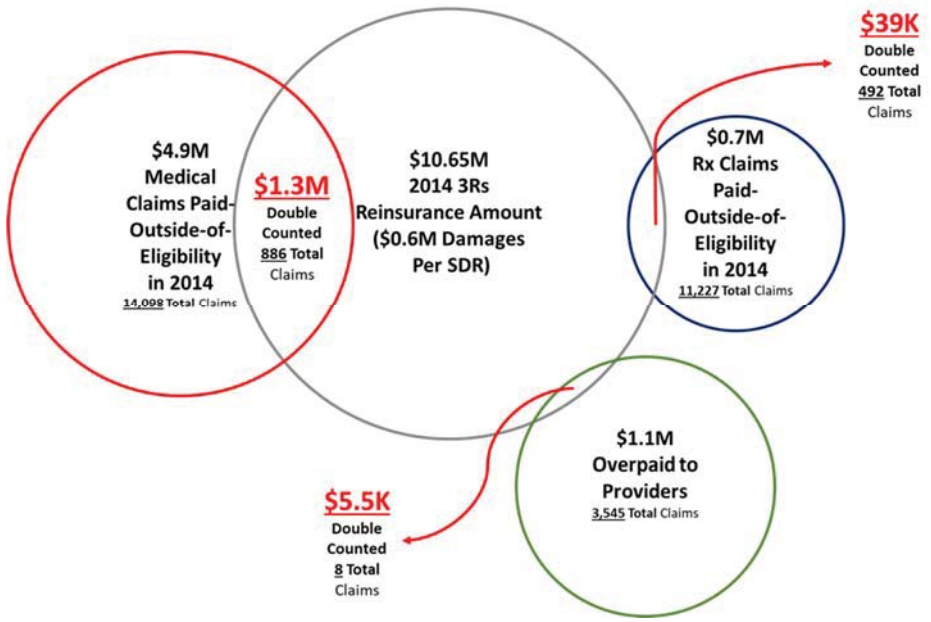
As mentioned, double counting is endemic in the DRAFT SDR Report's damage categories, something that was apparently missed by Fish in performing his "due diligence". Another example of double counting is related to the SDR's alleged damages regarding the supposed lost Federal 3Rs receivable and the other SDR damage categories, such as the 2014 overpayments and 2014 paid outside of eligibility damages.[325] Again, just as I discussed earlier, the SDR, Fish and Osowski double and triple count damages across these SDR damage categories and defendants.

For example, the SDR and Fish allege $572,757 of damages concerning the Federal Transitional Reinsurance submission.[326] This reinsurance submission includes claim numbers and paid amounts in the other damage categories that are double, and triple counted. That is, there are claim numbers in the Federal reinsurance submission that the SDR, Fish, and Osowski are considering "eligible" and are requesting this money from the Federal government, while simultaneously these same claim numbers are being considered as "ineligible" by the SDR, Fish and Osowski when requesting (alleged) damages from UHH for claims that allegedly should not have been paid (outside eligibility) or were overpaid. The diagram below shows that 26 percent of the alleged 2014 medical claims paid outside of eligibility are associated with claims that are being double counted in the Federal Reinsurance submissions and are

[324] The Venn diagram was created by comparing the values from Table 8 in the Fish Report II with the damages associated with claims paid after 4/30/2015 from the SDR's working paper on 2015 medical and Rx claims paid outside eligibility (PLAINTIFF02479920 and PLAINTIFF02479921). The date field used was *PaymentDate* from the *AdjudicationResult* table of the SDR's Javelina backup (PLAINTIFF02484563).
[325] DRAFT SDR Report, pp. 14-18. PLAINTIFF02479813-02479851 at 02479826-02479830.
[326] Fish Report II, Table 7 and DRAFT SDR Report, p. 17. PLAINTIFF02479813-02479851 at 02479829.

therefore, according to the SDR, Fish and Osowski, simultaneously "eligible" and "ineligible" depending on the entity from which the SDR is requesting damages.

Figure 4
Lost Federal 3Rs Receivable are Double-/Triple-Counted[327]



Characterizing claims as eligible in some instances and ineligible in other instances in order to put them in different damages categories and attribute them to UHH, on the one hand, and the Federal government, on the other, could allow the Receiver (on behalf of NHC) to recover a windfall from the alleged double and triple counting of damage dollars, by receiving twice the amount of money that the Receiver alleges NHC has been damaged. This double counting is easily seen by examining the SDR's damage calculations on an individual patient basis. For example, the DRAFT SDR Report's reinsurance calculation includes $126,152 of "eligible" payments for patient certification number 120000000667334, of which $81,720 is alleged damages. Simultaneously the DRAFT SDR Report's "2014 Medical Claims Paid Outside of Eligibility" include the same $126,152 as "ineligible" for patient certification number 120000000667334, thus double counting the $126,152 of claims in both calculations, resulting in a double count of $81,720 of alleged damages.

[327] The diagram was created by comparing the 2014 claims paid outside eligibility taken from SDR's working paper (PLAINTIFF02479810), claims with overpayments to providers taken from the SDR's working paper (PLAINTIFF02479807) and the claims alleged to be damaged with the claims associated with patients with Patient Cert Numbers found in the SDR's working paper on Federal Transitional Reinsurance (PLAINTIFF02479805). The claims were looked up in the *AdjudicationResult* table in the SDR's Javelina backup (PLAINTIFF02484563) using the Patient Cert Num.

The example below illustrates this double counting of damages for patient certification number 120000000667334.[328] The top snippet is from the DRAFT SDR Report's reinsurance working papers, while the bottom snippet is from the DRAFT SDR Report's working papers for the 2014 medical claims paid outside of eligibility. The total paid amount between the two is identical ($126,152), documenting the double-counting, of which $81,720 are double-counted damages. Put more simply, this means that if NHC were to collect on both damage categories, it would receive $207,872 = ($126,152 for the "ineligible" 2014 medical POE) + ($81,720 for "eligible" reinsurance) for claims that on which NHC only paid $126,152, a profit or windfall of either $81,720 or $126,152, depending on which one of the "eligible/ineligible" scenarios were true or of $207,872 if the claims were properly paid.

3R Reinsurance Double Counting Example

Reinsurance -*Patient Cert Number - 120000000667334*

	2014 Medical and RX Claims By Enrollee				In Network	Tot Med RX	FTR for		FTR
	(Active, Individual, Paid)	Medical	RX	Tot Med RX	MOOP	Claims Paid	GT45K	FTR for	Before
	Patient_Cert_Num Patient_Lastname Patient_Firstname	Claims Paid	Claims Paid	Claims Paid	Share Family	Less CSR MOOP	LT 250K	GT 250K	CSR MOOP
120000000667334	120000000667334 Schneider Charlene	126,151.59	568.21	126,719.80	-	126,719.80	81,719.80	-	81,719.80

Source: SDR Report, FN#41 - PLAINTIFF02479805

"Eligible" Reinsurance Dollars

Double Counted Damages

2014 Medical Claims POE - *Patient Cert Number - 120000000667334*

Nevada Health Co-Op Claims (Medical) Paid Outside Eligibility 2014

	Rows	Plan_ID_number	On_Off_ Individual_ Group	Metal_Level	Benefit_ Plan_Name	Product	Claimnumber	Fromdate	Through date	NetProvider PaymentAmt	Facility_Name
1	7364	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	214-000[illegible]5084-02	5/19/2014	5/19/2014	24.58	Comprehensive Cancer Centers of Nevada
2	7554	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	214-000003[illegible]70-02	5/20/2014	5/20/2014	23.41	Comprehensive Cancer Centers of Nevada
3	7555	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	214-000003617[illegible]02	5/20/2014	5/20/2014	39.86	Comprehensive Cancer Centers of Nevada
4	7556	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	214-000003617[illegible]02	5/20/2014	5/20/2014	68.44	Comprehensive Cancer Centers of Nevada
5	7557	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	214-000003623[illegible]00	5/20/2014	5/20/2014	24.68	Comprehensive Cancer Centers of Nevada
.	.	.	.	.	.	.	.	.	.	.	.
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.	.	.	.	.	.	.	.	.	.	.	.
.	.	.	.	.	.	.	.	.	.	.	.
441	33929	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	215-0000156235-00	12/24/2014	12/24/2014	327.53	Fremont Emergency Services
442	34078	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	215-0000196185-00	12/2/2014	12/[illegible]/2014	44.86	INFUSYSTEM, INC
443	34079	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	215-0000196186-00	12/17/2014	12/17/2014	44.86	INFUSYSTEM, INC
444	34080	34996NV003000101	OnExchange	P	Southern Star/Estrella Platinum Standard	MM	215-0000196186-00	12/13/2014	12/13/2014	246.65	INFUSYSTEM, INC
Total							444 Claims			$126,151.59	

Source: PLAINTIFF02479810

"Ineligible" 2014 Medical POE Dollars

The double counting of alleged damages across damage categories and between defendants is endemic throughout the major damage categories of the SDR, Fish and Osowski reports including but not limited to:

- 2014 and 2015 POE damages
- 2014-2015 overpayment
- The loss of the Federal receivable
- Out of pocket accumulators
- Damage amounts paid to UHH
- Uncollected Premiums from the State exchange -
- Table 8 of the Fish Report II – avoidable costs of additional losses in continued operation

[328] I identified the claims alleged to be paid outside eligibility for Patient Cert Num 120000000667334 using the *AdjudicationResult* table SDR's Javelina backup (PLAINTIFF02484563) and the SDR's working paper on 2014 claims paid outside eligibility (PLAINTIFF02479810). The "ineligible" amount ties out exactly with the total "eligible" amount for the same Patient Cert Num found in the SDR's reinsurance working paper (PLAINTIFF02479805).

- Table 9 of the Fish Report II – Premature and ill-prepared commencement of operations

All of this double-counting of alleged damages also flows through to Fish's calculation of interest on damages, which only further exacerbates the Receiver's double-counting of damages when interest is compounded.

The analyses and examples that I present above are only illustrative and do not identify the full extent of the SDR's, Fish's, and Osowski's double counting. The analyses demonstrate gross errors and inadequacies in the damage methodologies, calculations, and conclusions in the three reports, rendering the damage amounts deficient and therefore unreliable.

9.2 UHH and NHS Were Not Responsible for Claims Paid Outside of Eligibility

The SDR asserts that UHH was responsible for making determinations of a member's eligibility, and any resulting damages from claims paid outside of a member's eligibility are attributed to UHH.[329] The SDR also asserts that "An essential aspect of health claims adjudication is the determination of a member's eligibility before payment."[330] Contrary to the SDR's assertions that UHH was responsible for eligibility determinations, eligibility determinations were the responsibility of NHC, not UHH, as outlined in the NHC-UHH Administrative Services Agreement:

> "The CO-OP shall provide and/or direct the appropriate entity to provide regular scheduled eligibility, claims and other data transfers to TPA, as mutually agreed are necessary to perform the Administrative Services."[331]

Further, the ASA goes on to instruct UHH to refer to NHC for "any claims involving questions of eligibility."[332]

As outlined in the ASA, determination of a member's eligibility is a standard separation of responsibilities between a TPA and an insurance provider. The industry-standard in both health care claims processing and in general financial control situations is to have the duties of eligibility and claims payments separate, restricting the TPA's ability to both create plan members' eligibility and to pay their claims.

The SDR makes a highly questionable (and inaccurate) argument that UHH, in its role as TPA, was to override NCH's determinations of member eligibility, something that UHH had no authority to do. Without any support, the SDR assumes that UHH failed to exercise the authority it did not have and is now liable for the alleged damages associated with NHC's member eligibility determinations.

[329] DRAFT SDR Report, Section IV.A. PLAINTIFF02479813-2479851 at 02479816-2479819.
[330] DRAFT SDR Report, p. 5. PLAINTIFF02479813-2479851 at 02479817.
[331] ASA, p. 4. UHH0000006-0000033 at 0000009.
[332] ASA, p. 18. UHH0000006-0000033 at 0000023.

NHC's role as the entity responsible for determining a member's eligibility is made clear in an NHC document called "Eligibility Determination Process, Effective 8/12/2014."[333] This document contains a list of four steps that "should be used to determine a member's eligibility and the accuracy of any enrollment data."[334] While both NHC and Xerox are mentioned in these four steps, UHH is not mentioned at all.

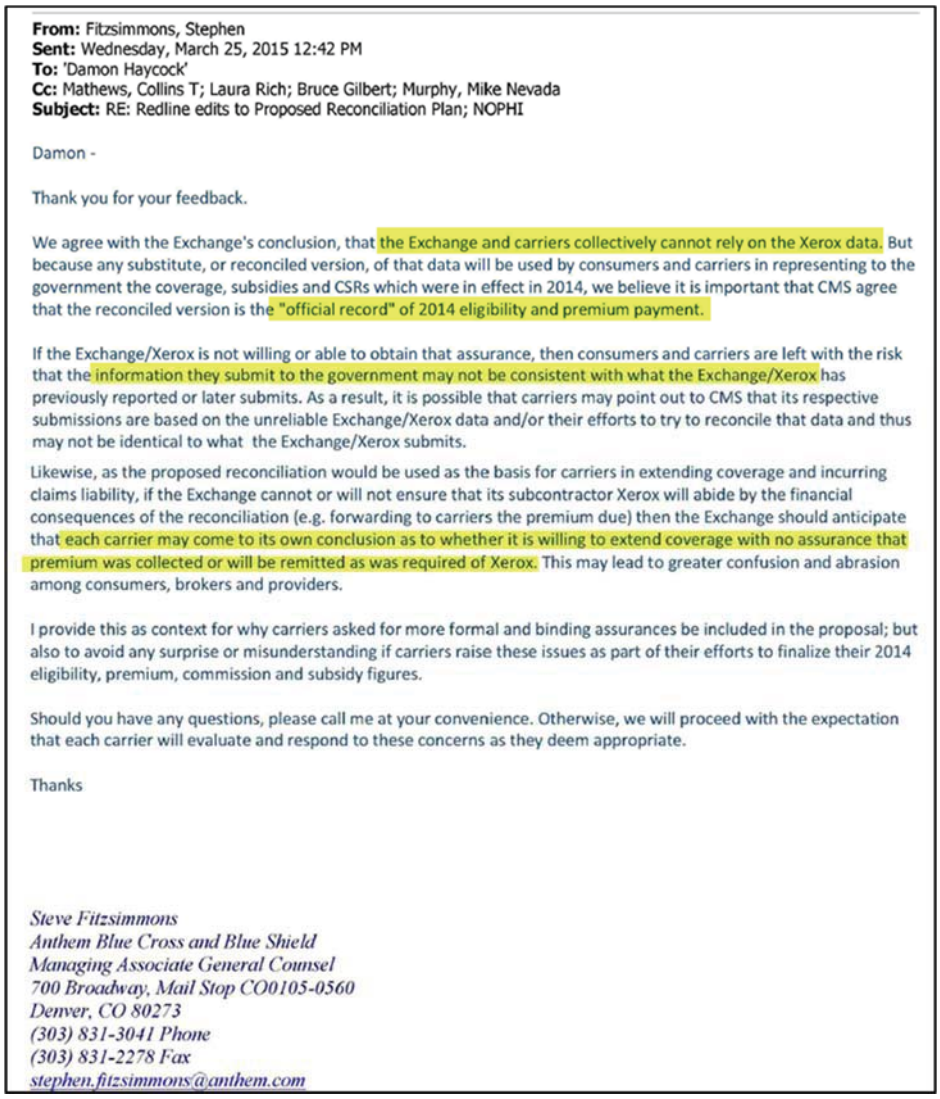
Furthermore, the State Exchange enrollment data maintained by Xerox and used by NHC to determine eligibility was known to be unreliable**.** For health plan year 2014, NHC relied on enrollment data from the Silver State Health Insurance Exchange (the "State Exchange Data") for members who used the state-sponsored online health portal to enroll for insurance coverage.[335]

The SDR claims that this enrollment data, which was maintained by Xerox, was subject to monthly reconciliations with NHC's enrollment system.[336] However, he SDR provides no foundation as to the reliability of the monthly State Exchange Data to determine a member's eligibility. There were, in fact, many emails and communications at the time, indicating that the State Exchange Data were completely unreliable and could not be used to make accurate eligibility determinations. Additionally, "the SDR has been repeatedly told, the database was the work of Xerox, and the Exchange does not accept the data therein as accurate."[337] Nevertheless, the SDR still uses the State Exchange Data to attribute alleged damages for claims paid outside of eligibility to UHH.[338]

For example, the following is an email from Anthem Blue Cross and Blue Shield Managing Associate General Counsel that includes reference to NHC declaring that the State Exchange Data for 2014 cannot be relied upon for eligibility and premium payment and that each carrier will come to its own conclusion as to whether it is willing to extend coverage with no assurances that a premium was collected or will be remitted.[339] I note that this email, regarding 2014 member eligibility, is dated March 25, 2015.

[333] Eligibility Determination Process effective August 12, 2014. PLAINTIFF00080366.
[334] Eligibility Determination Process effective August 12, 2014. PLAINTIFF00080366.
[335] DRAFT SDR Report, p. 5. PLAINTIFF02479813-2479851 at 02479817.
[336] DRAFT SDR Report, p. 5. PLAINTIFF02479813-2479851 at 02479817.
[337] Letter from Heather Korbulic, Executive Director of Silver State Health Insurance Exchange, to Mark Bennett, Special Deputy Receiver of Nevada Health CO-OP, Regarding Nevada Health CO-OP ("NHC"); Demand for Payment of Underpaid Premium Amounts to NHC: Your File No. 70750-000, dated April 17, 2019. PLAINTIFF02499352-02499353 at PLAINTIFF02499352.
[338] DRAFT SDR Report, p. 6. PLAINTIFF02479813-2479851 at 02479818.
[339] Email between Steve Fitzsimmons, Managing Associate General Counsel of Anthem Blue Cross Blue Shield, and Damon Haycock, Silver State Health Insurance Exchange, Regarding Redline edits to Proposed Reconciliation Plan; NOPHI, dated March 6-26, 2015. PLAINTIFF01096199-01096204 at 01096201-0196202.

Figure 5
Email Chain from Anthem Blue Cross Blue Shield Associate General Counsel that Included the CO-OP[340]



From: Fitzsimmons, Stephen
Sent: Wednesday, March 25, 2015 12:42 PM
To: 'Damon Haycock'
Cc: Mathews, Collins T; Laura Rich; Bruce Gilbert; Murphy, Mike Nevada
Subject: RE: Redline edits to Proposed Reconciliation Plan; NOPHI

Damon -

Thank you for your feedback.

We agree with the Exchange's conclusion, that the Exchange and carriers collectively cannot rely on the Xerox data. But because any substitute, or reconciled version, of that data will be used by consumers and carriers in representing to the government the coverage, subsidies and CSRs which were in effect in 2014, we believe it is important that CMS agree that the reconciled version is the "official record" of 2014 eligibility and premium payment.

If the Exchange/Xerox is not willing or able to obtain that assurance, then consumers and carriers are left with the risk that the information they submit to the government may not be consistent with what the Exchange/Xerox has previously reported or later submits. As a result, it is possible that carriers may point out to CMS that its respective submissions are based on the unreliable Exchange/Xerox data and/or their efforts to try to reconcile that data and thus may not be identical to what the Exchange/Xerox submits.

Likewise, as the proposed reconciliation would be used as the basis for carriers in extending coverage and incurring claims liability, if the Exchange cannot or will not ensure that its subcontractor Xerox will abide by the financial consequences of the reconciliation (e.g. forwarding to carriers the premium due) then the Exchange should anticipate that each carrier may come to its own conclusion as to whether it is willing to extend coverage with no assurance that premium was collected or will be remitted as was required of Xerox. This may lead to greater confusion and abrasion among consumers, brokers and providers.

I provide this as context for why carriers asked for more formal and binding assurances be included in the proposal; but also to avoid any surprise or misunderstanding if carriers raise these issues as part of their efforts to finalize their 2014 eligibility, premium, commission and subsidy figures.

Should you have any questions, please call me at your convenience. Otherwise, we will proceed with the expectation that each carrier will evaluate and respond to these concerns as they deem appropriate.

Thanks

Steve Fitzsimmons
Anthem Blue Cross and Blue Shield
Managing Associate General Counsel
700 Broadway, Mail Stop CO0105-0560
Denver, CO 80273
(303) 831-3041 Phone
(303) 831-2278 Fax
stephen.fitzsimmons@anthem.com

As the Anthem Blue Cross and Blue Shield Associate General Counsel's email outlines, the State Exchange was having great difficulty in providing Nevada insurance carriers with reliable enrollment information and the insurance carrier (i.e., NHC not UHH) was responsible for making the eligibility determinations given the contemporaneous information available.[341] These member enrollment decisions were made ad-hoc by NHC and required an individualized review of the member's claim and enrollment history.

[340] Email between Steve Fitzsimmons, Managing Associate General Counsel of Anthem Blue Cross Blue Shield, and Damon Haycock, Silver State Health Insurance Exchange, Regarding Redline edits to Proposed Reconciliation Plan; NOPHI, dated March 6-26, 2015. PLAINTIFF01096199-01096204 at 01096201-0196202.
[341] DeVito Report, p. 13-14.

Using their blanket determinations of member eligibility, the SDR alleges that $4.86 million in medical claims were processed and approved for payment by UHH in 2014 for members who were not eligible at the time.[342] These ineligibility findings by the Receiver's Experts, however, were made months, and even years, after the actual claim submissions. The SDR's current findings which are based on updated and corrected State Exchange premium payment data was simply not available at the time these claims were adjudicated and approved for payment.[343]

In addition to not using the contemporaneously available enrollment data to quantify alleged eligibility damages, the SDR chose to ignore that it was NHC, (not UHH) that was responsible for eligibility determinations. The contemporaneous Javelina data supports this finding by showing that nearly all of the claims allegedly paid outside of eligibility in 2014 were based upon eligibility determinations that were made by NHC staff not UHH staff.

I analyzed all of the medical claims allegedly paid outside of eligibility using Javelina eligibility data. My analysis shows that 94.2 percent of the SDR's $5.59 million in alleged damages for claims paid outside of eligibility were, in fact, paid for eligible members. The remaining 5.8 percent of the SDR alleged damages would need to have an individualized investigation to confirm whether each claim was in fact paid outside of eligibility, and if so, what the cause(s) of the outside of eligibility payment were.[344] As shown in Table 8, the SDR attributes $5.59 million in alleged damages due to claims paid outside of eligibility, when, in fact, only $325,981 ($5,593,352 alleged by the SDR less $5,267,371 that was paid within the eligibility period) was potentially paid outside of eligibility.

[342] DRAFT SDR Report, p. 5. PLAINTIFF02479813-2479851 at 02479817.
[343] DRAFT SDR Report, p. 5. PLAINTIFF02479813-2479851 at 02479817.
[344] For example, two claims (214-0000044905-00, 214-0000114800-00) that initially appeared to be ineligible via a computer query were in fact processed correctly and paid within the eligibility period when a simple review of the claims history and notes was performed.

Table 8
Claims Paid Outside of Eligibility[345]

Type	Alleged SDR Paid Outside of Eligibility Damages	Paid *Within* Eligibility Period	Percent of SDR Damages
Medical	$4,861,542	$4,620,460	95.0%
Rx	$731,810	$646,911	88.4%
Total	**$5,593,352**	**$5,267,371**	**94.2%**

9.3 The Number and Value of Overpaid Claims is Substantially Overstated

The SDR identifies categories of allegedly overpaid claims that overlap with other SDR damage categories (2015 claims paid outside of eligibility in particular) by as much as 90 percent (as is illustrated and discussed earlier in this report). The overlap demonstrates that these claims have a multiplicity of issues that should be disentangled, and a causal analysis should be performed to determine damages, which neither the SDR nor Plaintiff's experts undertook.

The existence of a 90 percent overlap renders the overpaid damages to be deficient and unreliable. In addition, the method used in the SDR's overpayment analysis uses an apparently ineffective keyword search, and not a thorough detailed claim review. The SDR alleges that UHH overpaid medical claims in health plan years 2014 and 2015.[346] Under the false premise that UHH is solely responsible for any overpayments, the SDR attempts to use, albeit in vain, an unreliable text-search methodology to classify 3,549 alleged instances of overpayments.[347] Simply stated, the SDR employs a simple keyword search on the notes section of claim records within the Javelina system in an attempt to identify categories of claims with alleged overpayments without actually assessing the validity of the claim or its paid amount and whether the alleged damage amount was caused by UHH. The SDR concludes, without any substantive analysis or evidence, that a claim amount should be categorized as alleged damages and associated with UHH when a claim number shows up in their arbitrary keyword search methodology.

[345] Eligibility periods were determined using information from the *EmpEligibilityCoverage* table from the SDR's Javelina SQL backup (PLAINTIFF02484563) for claims incurred in 2014. The *EmployeeID* and *Claimnumber* fields from the *AdjudicationResult* table, also from the SDR's Javelina SQL backup (PLAINTIFF02484563), were used to link the information from the Plaintiff's 2014 Paid Outside of Eligibility damages workbook (PLAINTIFF02479810) to the *EmpEligibilityCoverage* table. Paid amounts for Medical claims were identified using the *NetProviderPaymentAmt* field from the 2014 Paid Outside of Eligibility damages workbook (PLAINTIFF02479810). Paid amounts for Rx claims were identified using the *Net_Payment* field in the 2014 Paid Outside of Eligibility damages workbook (PLAINTIFF02479810). If the *EmpEligibilityCoverage* table showed the employee was active at the time the claim was incurred, then it was deemed to have been paid within eligibility. I understand that NHC was operating under "presumed eligibility" and therefore any potential damages may be overstated. See NHC Board of Directors Minutes for January 22, 2014. LARSON014362-LARSON014366; and NHC Board of Directors Minutes for April 29, 2014. LARSON014377-LARSON014383.
[346] DRAFT SDR Report, Section IV.B. PLAINTIFF02479813-2479851 at 02479819-2479821.
[347] Claims Overpayment Refund Amounts By Key Word Found in Claims Notes. PLAINTIFF02479807.xlsx.

The alleged damages associated with these 3,549 claims are the result of an undocumented workflow performed by the SDR staff. There is no supporting documentation to assess the validity of the SDR staff's determination of an overpayment or even what the cause of the overpayment was, or which entity was responsible. For example, an alleged overpayment could have been the result of NHC's, UHH's, InsureMonkey's, or another unknown entity's actions. The DRAFT SDR Report is silent on such issues and apparently assigns fault to UHH as long as the SDR staff member entered comments such as "provider" or "termed" or "policy" or "requested a refund from a provider". The SDR fails to provide any evidence that these overpayments were in fact overpayments and are a result of UHH's actions. The keyword searches on the Claims Note data performed by the SDR are as follows:

Figure 6
SDR workpapers - Claims Overpayment Refund Amounts By Key Word Found in Claims Notes

	B	C	D	F
1	**Total of $1,163,852 in Uncollected**			
2	**Claims Overpayment Refund Amounts**			
3	**By Key Word Found In Claims Notes**			
4				
5	Overpayment	$947,806	81.4%	Comment: In the over 3500+ Claim IDs with over $1.1 Mil in Uncollected Claims Overpayment Refund Amounts, it was not surprising to observe that the most frequent words found were "overpayment" and "provider". Because the Claims Notes section involved Claims personnel typing in their own words as opposed to selecting applicable reason code(s) for each Claims Overpayment amount, then the reasonable option was to manually scan for at least the top 20 key words present in each of the 3500+ Claim IDs with an uncollected claims overpayment refund amount. After the key words were identified, the data was filtered to sum the uncollected claims overpayment refund amounts. There are overlaps where more than 1 key word is found in the Claim Notes of a Claim ID such as the word "overpayment" and the word "provider" is found in a Claim Note for a particular Claim ID. As a result, the aggregate of the uncollected claims overpayment refund amounts is $2.6 Mil even though the total of uncollected claims overpayment refund amounts is only $1.1 Mil.
6	Provider	$834,288	71.7%	
7	Termed	$129,975	11.2%	
8	Policy	$120,143	10.3%	
9	Miscellaneous	$115,633	9.9%	
10	Authorization	$96,419	8.3%	
11	Service	$83,476	7.2%	
12	Reduction	$50,499	4.3%	
13	Svc Line	$50,306	4.3%	
14	#N/A	$41,978	3.6%	
15	Allowable	$38,733	3.3%	
16	Network	$26,632	2.3%	
17	Eligibility	$25,937	2.2%	
18	Coverage	$18,169	1.6%	
19	Duplicate	$17,747	1.5%	
20	Incorrect	$13,700	1.2%	
21	Procedure	$10,973	0.9%	
22	Hospital	$4,090	0.4%	
23	Co-Pay	$3,187	0.3%	
24	Wrong	$3,032	0.3%	
25	WellHealth	$1,390	0.1%	
26	**Aggregate (not total)**	**$2,634,113**	**100.0%**	
27				

The above snapshot from the SDR workpapers[348] describes how the SDR also double counted unpaid amounts, recounting the $1,163,852 being counted and summed up multiple times as they attempt to categorize their unsubstantiated overpayment amounts.

The SDR is also attributing damages to UHH for claim numbers that never even existed while UHH was performing TPA services for NHC, only further documenting and highlighting the unreliable nature of the SDR analysis. As reflected below, the SDR's spreadsheet[349] includes damages and claim numbers for

[348] Claims Overpayment Refund Amounts By Key Word Found in Claims Notes. PLAINTIFF02479807.xlsx.
[349] Claims Overpayment Refund Amounts By Key Word Found in Claims Notes. PLAINTIFF02479807.xlsx.

dates incurred after UHH was no longer the TPA, with some costs incurred as late as in 2018. The SDR analysis of overpaid claims using a key-word search is unreliable.

Figure 7
SDR workpapers - Claims Overpayment Refund Amounts By Key Word Found in Claims Notes

C	D	E	F	G	H	I	J
CLAIM NUMBER	Full 15 digit Claim ID No per Mike K	DATE INCURRED	PROVIDER TAX ID	FACILITY	OVERPAYMENT AMOU	SDR LETTER SENT	NOTES
215-0000654285-00	215-0000654285-00	9/22/2015	481267451	WEE CARE PEDIATRICS	1.91	06/26/17	REQUEST REFUND FROM PATIENT. 08/09/2017
215-0000654544-00	215-0000654544-00	9/22/2015	880182329	CARDIOLOGY & CARDIOVASCULAR CONS	71.73	06/26/17	
215-0000654107-00	215-0000654107-00	9/23/2015	203516398	ADVANCED PAIN MANAGEMENT CENTER	122.64	06/26/17	
215-0000758338-00	215-0000758338-00	10/21/2015	043290453	HARMONY HEALTHCARE	78.75	06/26/17	
215-814480-00	215-0000814480-00	11/17/2015	043290453	PHC OF NEVADA HARMONY HEALTH	78.75	05/26/17	
215-849916-00	215-0000849916-00	11/24/2015	880384150	GREEN VALLEY OB/GYN ASSOCIATES	699.66	02/15/18	50% hardship payment, per SDR send letter to request refunds. 2/14/2018 EP
215-829936-00	215-0000829936-00	12/4/2015	043290453	PHC OF NEVADA HARMONY HEALTH	78.75	05/26/17	
216-29551-00	216-0000029551-00	12/10/2015	880384150	GREEN VALLEY OB/GYN ASSOCIATES	74.73	05/22/17	50% hardship payment, per SDR send letter to request refunds. 2/14/2018 EP
215-273116-00	215-0000273116-00	4/17/2018	043290453	PHC OF NEVADA HARMONY HEALTH	43.25	05/10/17	
215-428428-00	215-0000428428-00	6/17/2018	200562668	NEVADA HEART AND VASCULAR CENTER	476.31	05/11/17	
215-276663-00	215-0000276663-00	4/21/2115	880367250	PEDIATRIX MEDICAL GROUP OF NEVADA	293.22	04/28/17	PROVIDER RESPONDED NO REFUND WILL BE MADE DUE TO LACHES. 06/08/2017

9.4 2014-2015 Duplicate Claims Payments

In its draft report, the SDR indicates it commissioned an effort to identify duplicate payments for the plan year 2014. The SDR then indicates that a minimum of $133,888.94 of duplicate payments were made and that these duplicate payments were caused by UHH.[350] This damages calculation, like the others in the DRAFT SDR Report which were adopted by Fish and Osowski, fail to demonstrate or otherwise offer any evidence that UHH and/or NHS were substantial factors causing an alleged duplicate payment. Instead, in its draft report, the SDR presents unrelated working papers to support their alleged damages claim.[351] It is unclear which supporting materials Fish and Osowski reviewed to allow them to adopt the DRAFT SDR Report's unsubstantiated alleged damages.

The Plaintiff's subsequent working paper production related to duplicate payments[352] fails to demonstrate duplicate payments were in fact made, and that UHH was the cause of these alleged duplicate payments. The SDR, Fish, and Osowski's failure to consider the many actions and decisions taken by NHC, NHC's other vendors, including Xerox, WellHealth[353],and InsureMonkey, that influenced claims processing, means that the $133,888.94 alleged damage finding is unreliable and deficient.

9.5 Loss of Federal Receivables

Fish fails to disclose that NHC, and Non-UHH personnel, performed the inaccurate 3R estimations and calculations, not UHH. Fish's Table 7 identifies each of the 3R category calculations as the NHC filed them in 2014 versus what was subsequently recalculated by the SDR or Indegene.[354] The overall difference between these three different 3R calculations is $6.175 million, the amount that Fish asserts

[350] DRAFT SDR Report, Section IV.C. PLAINTIFF02479813-2479851 at 02479821-2479822.
[351] PLAINTIFF02479805.
[352] PLANTIFF02498744, PLANTIFF02499016.
[353] Many of these unconsidered operational issues and NHC decisions surrounding WellHealth are documented in the CCI Report.
[354] Indegene was the CO-OP's retained financial and actuarial consultant. See Fish Report II, p. 24. Table 7.

as alleged damages attributable to UHH.[355] Fish asserts, without any evidence, that the driver of the difference between the two calculations is "UHH's failure to adjudicate NHC's claims on an accurate and timely basis."[356] However, Fish fails to discuss or disclose what caused NHC's incorrect 3R's submission or what the source of the error was. After looking through the Receiver's working papers, it is my opinion that the primary cause of the $6.175 million difference is NHC's failure to accurately estimate and input accounting entries in the CMS Excel templates for the 3R's calculations. It was not anything that UHH did or failed to do.

The 3Rs calculations are an actuarial and accounting-driven process, not a TPA-driven process. In fact, the primary contemporaneous emails and discussions regarding the preparation of NHC's submission of 3R calculations to CMS do not materially involve UHH employees. Specifically, there were many email exchanges between NHC finance personnel and Milliman regarding how to complete the CMS 3R template and what adjustments and corrections were needed. For example, on July 29, 2015, two days before NHC's risk corridor submission was due to CMS, NHC's Chief Financial Officer(Basil Dibsie) requested assistance from Milliman to review his preparation of this receivable.[357] In this email, Dibsie states that the results of the risk corridor calculation are higher than the original estimate and that he would like Milliman to review the submission for "reasonableness." More specifically, only two days before this submission was due to CMS, Dibsie's risk corridor calculations were roughly $15 million, $5 million higher than NHC's original estimate of $10 million[358].

From: Basil Dibsie
Sent: Wednesday, July 29, 2015 4:51 PM
To: Jill Van Den Bos <jill.van.den.bos@milliman.com>
Subject: MLR & Risk Corridor
Importance: High

Hi Jill,
I am almost complete with my MLR & RC models. If I send them to you, is there someone at Milliman that can do a review for reasonableness? I am coming up quite a bit higher at $14,641,967 for Individual and $310,050 for Small Group totaling $14,952,017. As compared to the $10M original estimate. I will also send some of my back-up worksheets used. Please let me know. Thanks,

nhc nevada health co-op
simply better

Basil Dibsie
Chief Financial Officer

3900 Meadows Lane | Suite 214 | Las Vegas, NV 89107
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www.nevadahealthcoop.org

[355] Fish Report II, p. 24. Table 7.
[356] Fish Report II, p. 32. No. 4.
[357] Email between Basil Dibsie, Chief Financial Officer of NHC, and Jill Van Den Bos, ASA, MAAA, MA, Senior Consultant of Milliman, regarding MRL & Risk Corridor, dated July 30, 2015. PLAINTIFF01045249-01045250 at 01045250.
[358] Email between Basil Dibsie, Chief Financial Officer of NHC, and Jill Van Den Bos, ASA, MAAA, MA, Senior Consultant of Milliman, regarding MRL & Risk Corridor, dated July 30, 2015. PLAINTIFF01045249-01045250 at 01045250.

Five hours after Dibsie's request to Milliman for assistance reviewing this unexpected result, he emailed Milliman (presented below) again to say, "actually I had a revision and now it's ~11.6M."[359]

From: Basil Dibsie [mailto:bdibsie@nevadahealthcoop.org]
Sent: Wednesday, July 29, 2015 9:42 PM
To: Jill Van Den Bos <jill.van.den.bos@milliman.com>
Cc: Katie Matthews <Katie.Matthews@milliman.com>; Travis Gray <travis.gray@milliman.com>
Subject: RE: MLR & Risk Corridor

Actually I had a revision and now it's ~$11.6M.

Dibsie's risk corridor calculation went from a $10 million estimated receivable to a $15 million receivable, back down to $11.6 million, all over the course of one day, just 48 hours before the submission was due to CMS. The confusion regarding the risk corridor receivable continued through July 31, 2015, the day that this receivable was due. In an email from Milliman to Dibsie, two pages of comments and questions are presented based upon their review of his risk corridor model.[360]

Importantly, no UHH employee was party to this email exchange, nor was anyone from UHH asked to review or perform due diligence on the claims-related entries that NHC employees entered into the spreadsheet. Yet Fish attributes damages to UHH for actuarial and accounting calculations, and submission errors for which UHH, as the TPA, was not involved.

The CMS risk corridor submission template allows for a claims backlog to not adversely affect the submitting entity -- NHC simply fails to make an accurate submission. The CMS risk corridor submission template allows for the existence of a claims backlog and for the CO-OP to enter accounting estimates into the template to appropriately control for a 2014 claims backlog.[361] In other words, the CMS risk corridor template allowed NHC to get the same risk corridor payment irrespective of the size of the claims backlog, as long as NHC correctly entered the actuarial and accounting entries into the template. The template has an input for the estimated total claims incurred in 2014 but not paid as of March 31, 2015.[362] This was one of the key accounting inputs that NHC did not accurately estimate and is the primary driver of Table 7's $6.175 million difference in 3R calculations. The 2014 claims that were incurred, but not yet paid before March 31, 2015, is a number inputted into NHC's risk corridor submissions by NHC. These actuarial calculations and accounting entries did not involve UHH.

In fact, NHC could have performed a similar claims backlog analysis at the time of its first submission as that recently performed by the SDR, which is now presented in Fish's Table 7. For example, Fish

[359] Email between Basil Dibsie, Chief Financial Officer of NHC, and Jill Van Den Bos, ASA, MAAA, MA, Senior Consultant of Milliman, regarding MRL & Risk Corridor, dated July 30, 2015. PLAINTIFF01045249-01045250 at 01045249.
[360] Email from Katie Matthews, Actuarial Assistant of Milliman, to Basil Dibsie Regarding MLR & Risk Corridor Review Notes, dated July 31, 2015. PLAINTIFF001243342-1243343.
[361] Center for Medicare & Medicaid Services (CMS) Medical Loss Ratio (MLR) Annual Reporting Form Filing Instructions for the 2014 MLR Reporting Year. PLAINTIFF00188885-000188938. See also PLAINTIFF00179755.
[362] PLAINTIFF02479890, Pt 2, Line 2.2b.

presents a claims run-off analysis[363] and documents the type of analysis that was available to NHC at the time of its first risk corridor submission. Fish's actuarial analysis highlights the fact that NHC's risk corridor submission deficiency was due to an NHC failure that had nothing to do with UHH or the scale of NHC's claims backlog, but ultimately with NHC's actuarial and accounting failures.

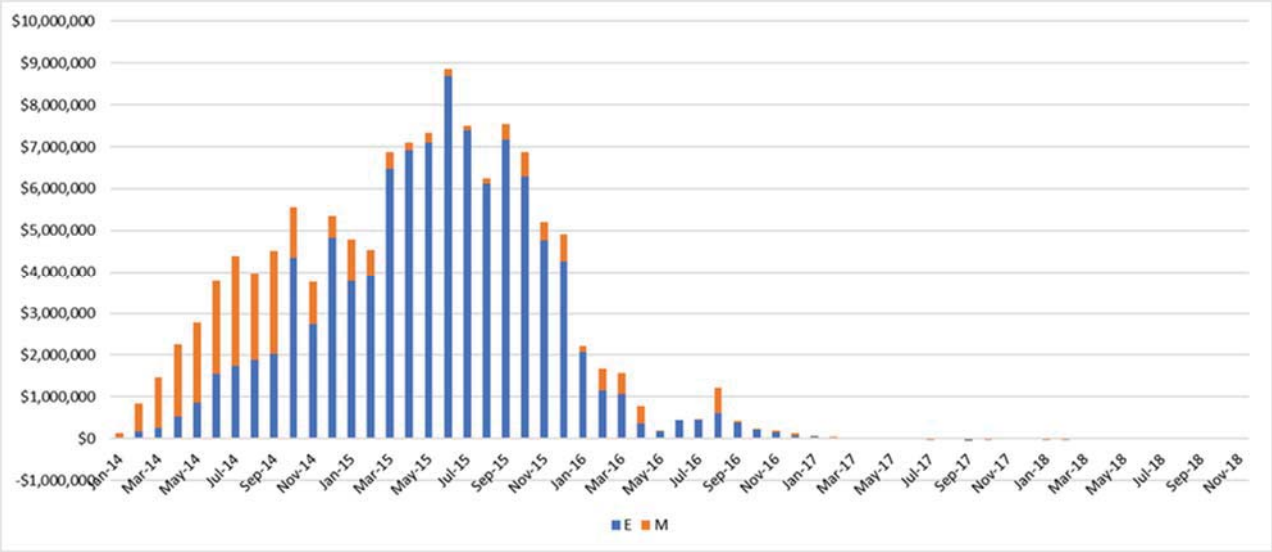
Lastly, NHC went through a data validation and resubmission process in September 2015 for its 2014 risk corridor filing[364], making a submission to CMS on September 14, 2015[365]. Even after going through this data validation and resubmission process, NHC failed to make an accurate submission of its risk corridor irrespective of the claims backlog red herring.

Fish presents misleading claims backlog charts without any analysis of the causes and context of the backlog. Further, Fish presents a series of misleading backlog charts[366] without any context or analysis as to the cause of the claims backlog. In fact, Fish fails to show that UHH caused any of his calculated claims backlog and if so, what proportion of the backlog was caused by (i) UHH's actions versus NHC decisions, (ii) failures of the State Exchange and Xerox, (iii) InsureMonkey, (iv) Eldorado, or (v) any of the other litany of factors that can cause a claim processing delay. This failure of establishing causation between UHH's actions and a claims backlog is consistent with the fact that NHC was responsible for its failure to submit its 3R calculations properly, and now the SDR and Plaintiff's experts attempt to attribute damages to UHH to for what are actually NHC's mistakes.

For example, without providing context or explanation, Fish opines that insurance companies "…pay claims at a very high rate (e.g., 98 percent) within 30 days…"[367] and that NHC experienced "…major prompt pay issues, particularly at its outset and throughout 2014."[368] Fish fails to disclose that NHC, at the beginning of 2014, was receiving the majority of its claims in *paper* form rather than *electronic* form as originally envisioned in its business plans.[369] The figure below shows that during the initial days of the CO-OP, the majority of claims were submitted as paper claims.

[363] 2015 Actual Premium and Membership Revenue. PLAINTIFF02499092.xlsx.
[364] PLAINTIFF00179755.
[365] PLAINTIFF00177493.
[366] Fish Report II, pp. 25-26, Charts 1-4.
[367] Fish Report II, p. 27
[368] Fish Report II, p. 27.
[369] Email between Michael Gulling, Director, Claims Department of UHH, and Randy Plum, Director of Operations of NHC, Regarding Print to EDI, dated February 28, 2014. PLAINTIFF00049070-00049071.

Figure 8
Medical Claims Received by Type of Claim (Electronic vs. Paper)[370]



This high level of paper and manual claims processing renders Fish's 98 percent of claims being processed and paid within 30 days standard as irrelevant since most insurance companies would be receiving the vast majority of their claims in electronic form, which allows for more efficient and faster processing.

Fish's charts present the claims inventory over time but ignore claims processing improvements. By focusing on the claims inventory alone, Fish ignores UHH's improvements in claims processing over time and allows for the initial paper claims and State Exchange eligibility issues to grossly distort the performance metrics presented in Fish's charts 1-4. For example, concurrent UHH and NHC discussions regarding the claims backlog indicates that claims processing metrics dramatically improve as NHC's business operations matured, the volume of paper claims were reduced, and the difficulties of the State Exchange eligibility issues subsided. On February 2, 2015, the COO of NHC sent the claims manager of UHH an email congratulating UHH on the claims processing improvements and provided the following table describing the claims processing improvements.[371]

[370] Calculated for all medical claims in the *AdjudicationResult* table from the SDR's Javelina SQL backup (PLAINTIFF02484563). For claims with *BenefitPlanName* other than "RX Plan" and the type of claim is identified by the *ClaimSource* field which can have the value "E" for electronic claims and "M" for manual or paper claims.
[371] Email from Linda I. Mattoon, Chief Operating Officer of NHC, to Brooke D. Gearhart, Claims Manager of UHH, Regarding Claims Received and Processed 2014, dated February 2, 2014. PLAINTIFF00032486-00032487.

From: Gearhart, Brooke [/O=HEREIU-IL/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=BGEARHART]
Sent: 2/3/2015 2:18:12 PM
To: Mattoon, Linda [LMattoon@nevadahealthcoop.org]
Subject: RE: Claims Received and Processed 2014

That is nice to see, thank you for that little gift Linda!

Brooke D. Gearhart
Claims Manager
UNITE HERE HEALTH
711 N. Commons Drive, Aurora, IL 60504
Mobile: 630.450.0826
Desk: 630.236.5192
Fax: 630.786.1664
bgearhart@uniteherehealth.org

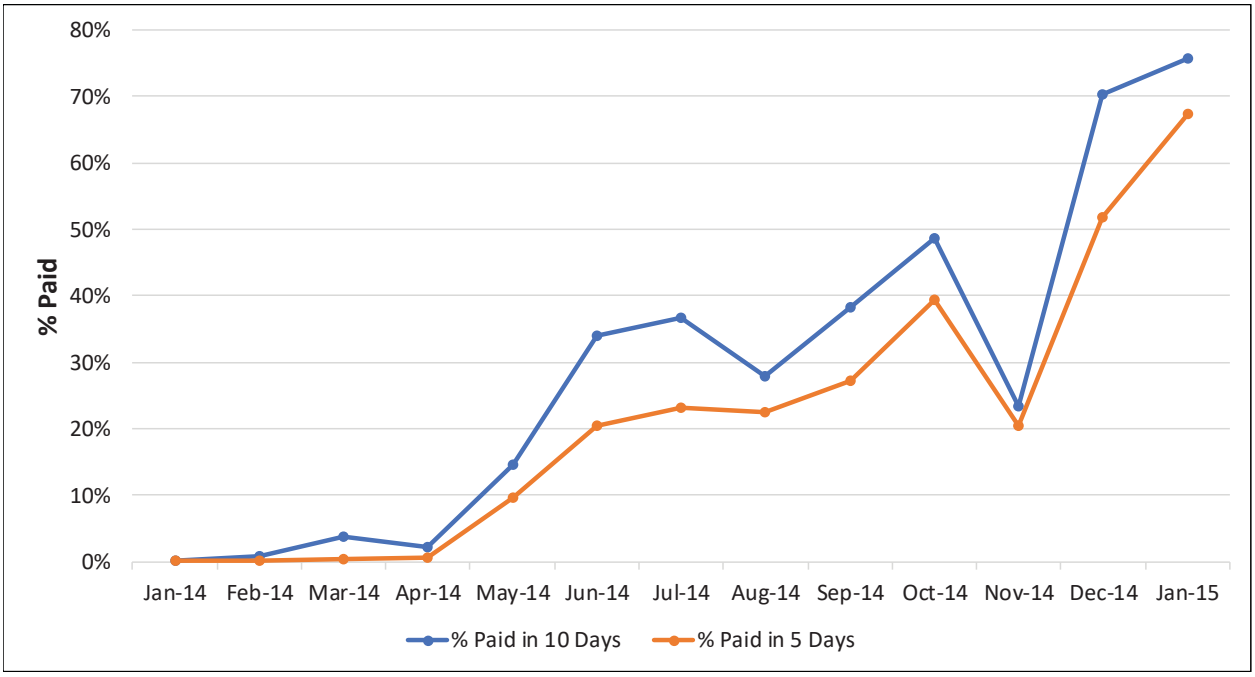
From: Linda I. Mattoon [mailto:lmattoon@nevadahealthcoop.org]
Sent: Monday, February 02, 2015 4:37 PM
To: Gearhart, Brooke
Subject: Claims Received and Processed 2014

Brooke – I'm pulling info together for the board meeting and thought I would share the following table with you since it demonstrates so well the progress that has been made and the increase in the volume of claims. We are usually focused on system problems, issues and the claims backlog and sometimes we forget what was accomplished – together UHH and NHC processed 259,444 claims…despite all the challenges! Nice!!

Number of Claims Received	Month Received	Number Paid in 10 Days	Percent Paid in 10 Days	Number Paid In 5 Days	Percent Paid In 5 Days
3,251	Jan-14	2	0.1%	2	0.1%
7,714	Feb-14	67	0.9%	9	0.1%
11,818	Mar-14	432	3.7%	32	0.3%
15,043	Apr-14	320	2.1%	103	0.7%
20,219	May-14	2,947	14.6%	1,968	9.7%
21,851	Jun-14	7,404	33.9%	4,447	20.4%
24,339	Jul-14	8,922	36.7%	5,657	23.2%
31,558	Aug-14	8,830	28.0%	7,117	22.6%
32,105	Sep-14	12,286	38.3%	8,742	27.2%
36,102	Oct-14	17,545	48.6%	14,276	39.5%
33,187	Nov-14	7,739	23.3%	6,771	20.4%
36,376	Dec-14	25,605	70.4%	18,805	51.7%
31,648	Jan-15	23,980	75.8%	21,340	67.4%
273,563	Total Claims Received 2014				
14,119	Number of Unpaid Claims on 12.31.2014				
5.16%	Percent of Claims Unpaid				

Data in the COO's table are presented graphically below:

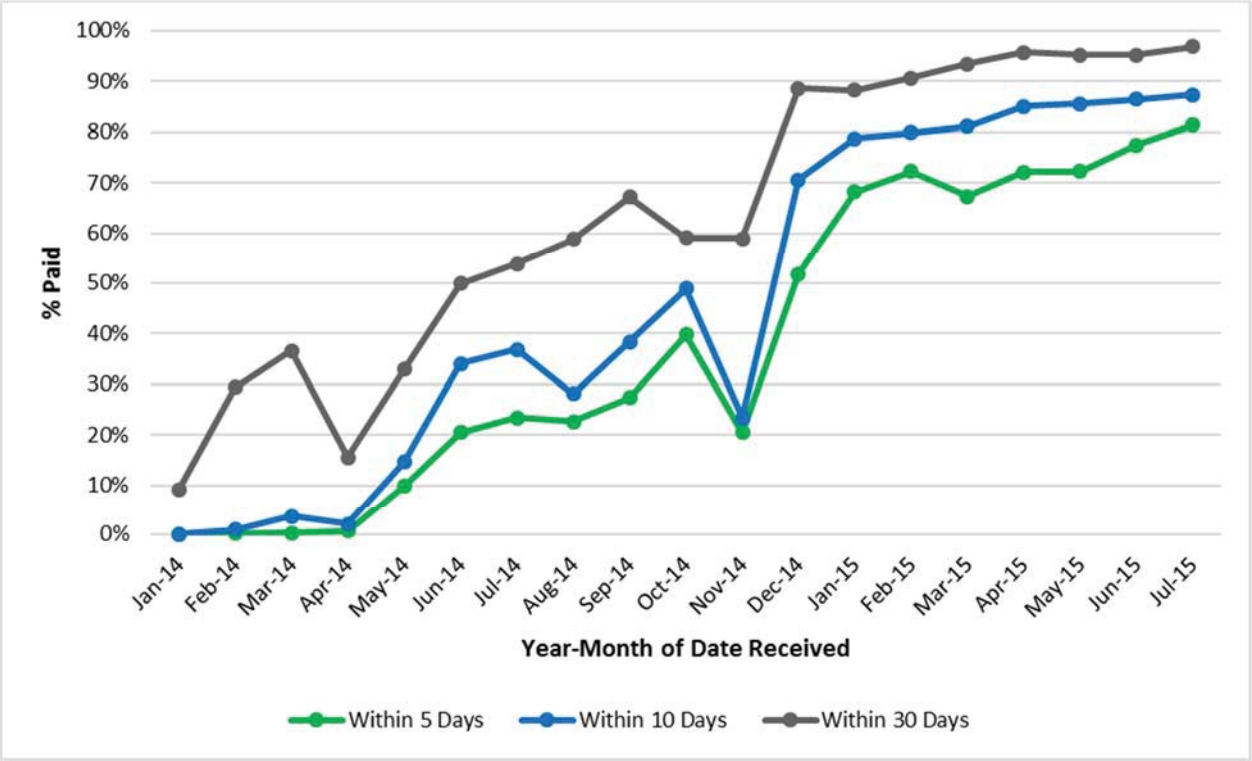
Figure 9
Percent of Claims Paid in 5 and 10 Days by Date Claim Received[372]



NHC's COO's claims processing metrics show that by January 2015, 76 percent of the claims received were processed within 10 days, up from 2.1 percent in April 2014. I performed a similar analysis as NHC's COO performed for claims received from 2014 to 2015 and find that by February 2015, over 90 percent of the claims were being processed within 30 days, and by April 2015, 95 percent of claims were processed within 30 days. The dramatic processing improvement for which NHC's COO was congratulating UHH is presented below:

[372] This chart is just a visual representation of the table in the email sent by the COO of NHC to the claims manager of UHH on February 2, 2015. The chart is aggregated by the month and year of when the claim was received.

Figure 10
Percent of Claims Paid in 5, 10 and 30 Days by Date Claim Received[373]



Additionally, not only does Fish's inventory analysis ignore the claims processing improvements described, it also fails to account for the instructions from NHC's CEO (Pam Egan) to focus on 2015 claims, making 2015 the priority rather than the 2014 claims backlog. This instruction of prioritizing 2015 claims is illustrated in an email dated January 6, 2015, from Linda I. Mattoon, NHC's COO, describing NHC's CEO's (Pam Egan) prioritization of the 2015 claims versus the 2014 claims backlog.[374]

[373] Calculated using the *AdjudicationResult* table from the SDR's Javelina SQL backup (PLAINTIFF02484563) for claims received from January 2014 to July 2015. The days taken to pay a claim is calculated as the difference between the *Datereceived* and *PaymentDate* fields.
[374] Email between Brooke D. Gearhart, Claim Manager of UHH, and Linda I. Mattoon, Chief Operating Officer of NHC, Regarding 2015 Claims, dated January 6-7, 2015. PLAINTIFF00033421-00033422 at PLAINTIFF00033421.

From: Linda I. Mattoon [mailto:lmattoon@nevadahealthcoop.org]
Sent: Tuesday, January 06, 2015 2:08 PM
To: Barbara Rodriguez; Sandoval, Christina; Gearhart, Brooke
Subject: 2015 Claims
Importance: High

Good Afternoon Ladies,

Pam would very much like us to keep 2015 claims current as we work on the 2014 backlog. We have identified three groups whose 2015 eligibility is not in Javelina yet:

1) Approximately 500 members that were in the JQS
2) Small groups
3) Pre-Audit File exceptions

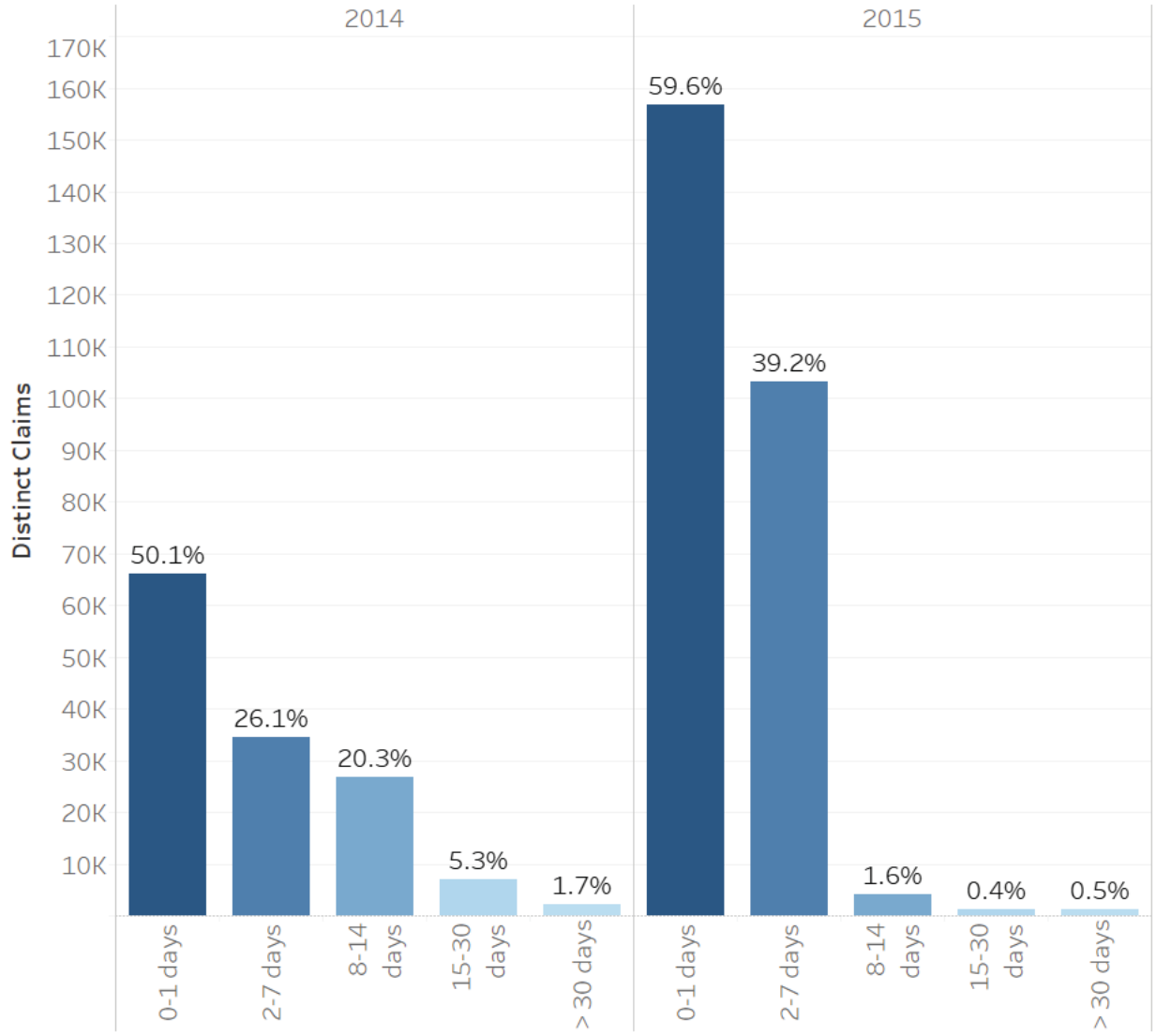
It may be the end of this week, possibly early next week, before all of the eligibility issues are straightened out and uploaded into Javelina. I am hopeful the eligibility will be straightened out before too many claims are received; however, since 2015 claims are a priority and we have known eligibility issues, would it be helpful to create a queue for 2015 eligibility issues?

Let me know your thoughts – thanks!

Fish's claims backlog inventories and processing metrics are misleading because he fails to account for NHC's CEO instructing UHH and CO-OP claims processing staff to prioritize the 2015 claims over the 2014 claims backlog. It is then misleading and inappropriate to use the 2014 claims backlog metrics against UHH when it was told to focus on 2015 claims. In fact, UHH did precisely as NHC instructed, focus and prioritize the 2015 claims over the 2014 backlog; the prior charts and tables on the monthly percent of claims paid in less than 30 days demonstrate continual improvement and execution of NHC's business prioritization.

Most importantly, Fish fails to recognize that regardless of the volume of unpaid claims, claims were entered into Javelina on a timely basis, meaning the data were available and could have been used to control for a claims back log. As reflected in the figure below, 96.5 percent of claims in 2014 and 98.8 percent of claims in 2015 were entered into Javelina between 0-14 days from the date received evidencing no significant lag in data availability (over 50 percent in both years were entered into Javelina within 0-1 days).

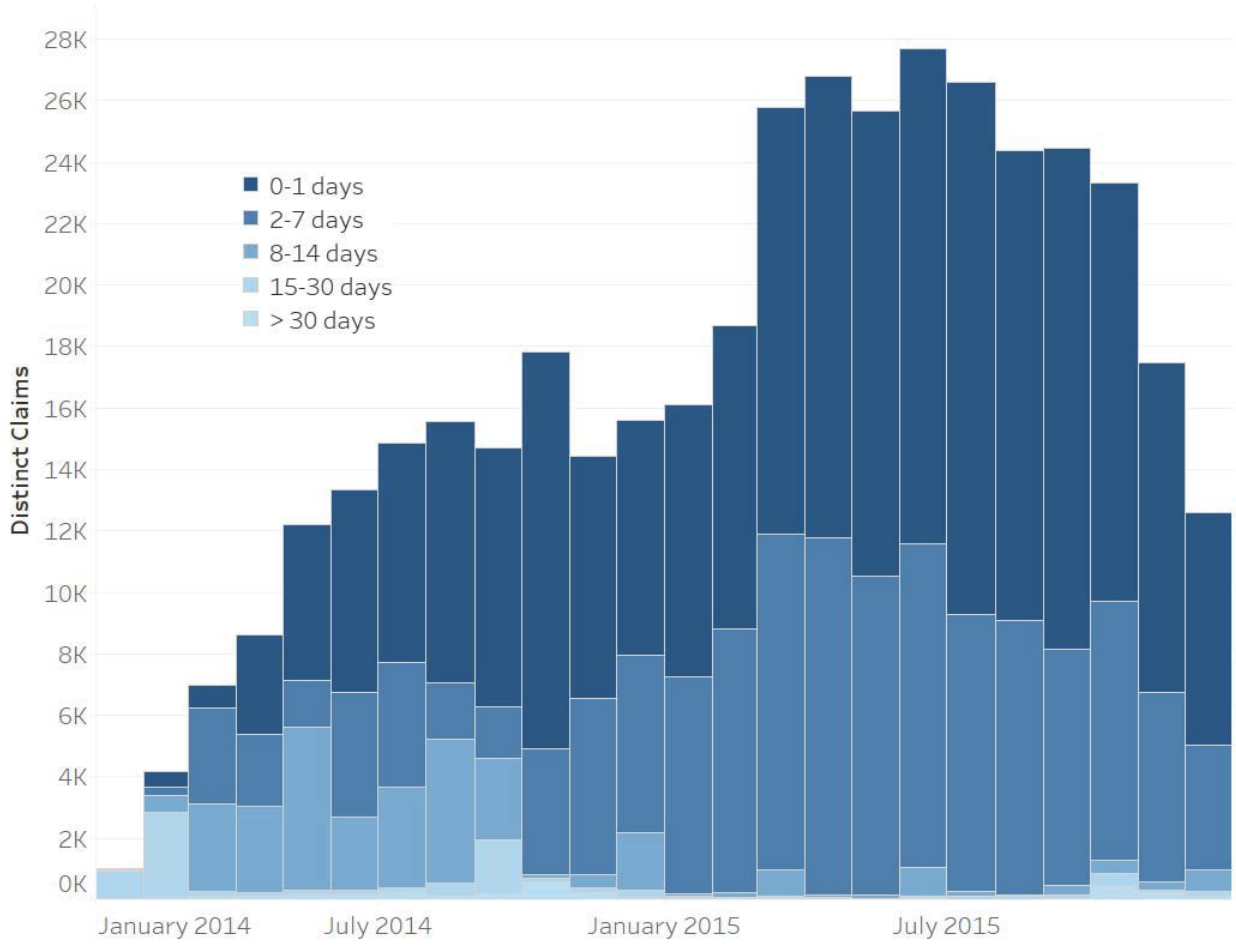
Figure 11
Days Taken to Enter Claims in Javelina[375]



[375] Calculated using the *AdjudicationResult* table from the SDR's Javelina SQL backup (PLAINTIFF02484563) for all claims received in 2014 and 2015 having *BenefitPlanName* values other than "RX Plan". The days taken to enter a claim in Javelina was calculated as *CreatedDate* - *Datereceived*. The chart shows the volume of claims (# of distinct 14-digit *Claimnumber*) in (i) 0-1 day, (ii) 2-7 days, (iii) 8-14 days, (iv) 15-30 days and (v) more than 30 days. Claims with a *CreatedDate* value that comes before the *Datereceived* are excluded. I also aggregated the charts by Month-Year of *Datereceived* and looked at the claims volume each month from January 2014 - December 2015.

As reflected in the figure below, by the end of 2014 and into 2015, a majority of the claims were entered into Javelina between 0-7 days.

Figure 12
Days Taken to Enter Claims in Javelina[376]



Fish claims he "reviewed" the 3R calculations and that they are "reasonable" even though his own working papers appear to contradict the 3R calculations he presents in Table 7. In addition to failing to establish or demonstrate that the claims backlog was caused by UHH and that the claims backlog caused NHC to make its allegedly inaccurate submissions, Fish appears to have performed work that contradicts the recalculated amounts he presents as "reasonable"[377] damages in Table 7 of his report.

[376] Calculated using the *AdjudicationResult* table from the SDR's Javelina SQL backup (PLAINTIFF02484563) for all claims received in 2014 and 2015 having *BenefitPlanName* values other than "RX Plan". The days taken to enter a claim in Javelina was calculated as *CreatedDate* - *Datereceived*. The chart shows the volume of claims (# of distinct 14-digit *Claimnumber*) in (i) 0-1 day, (ii) 2-7 days, (iii) 8-14 days, (iv) 15-30 days and (v) more than 30 days. Claims with a *CreatedDate* value that comes before the *Datereceived* are excluded. I also aggregated the charts by Month-Year of *Datereceived* and looked at the claims volume each month from January 2014 - December 2015.
[377] Fish Report II, p. 23, FN #64-65.

Fish's working papers includes a "Claims Lag 2014" analysis which identifies when 2014 incurred claims were received and paid by NHC.[378] Fish uses these calculations for his revised IBNR Reserves - Table 2 and Table 8 but does not appear to cross-check his results with the amounts the SDR used for the revised Risk Corridor calculations. Nonetheless, Fish states the SDR's numbers are "reasonable."

For example, Fish's working papers show a total of $56.539 million paid for claims incurred in 2014 and received in 2014-2016.[379] His working papers also show a total of $5.696 million of 2014-incurred claims received after December 31, 2014.

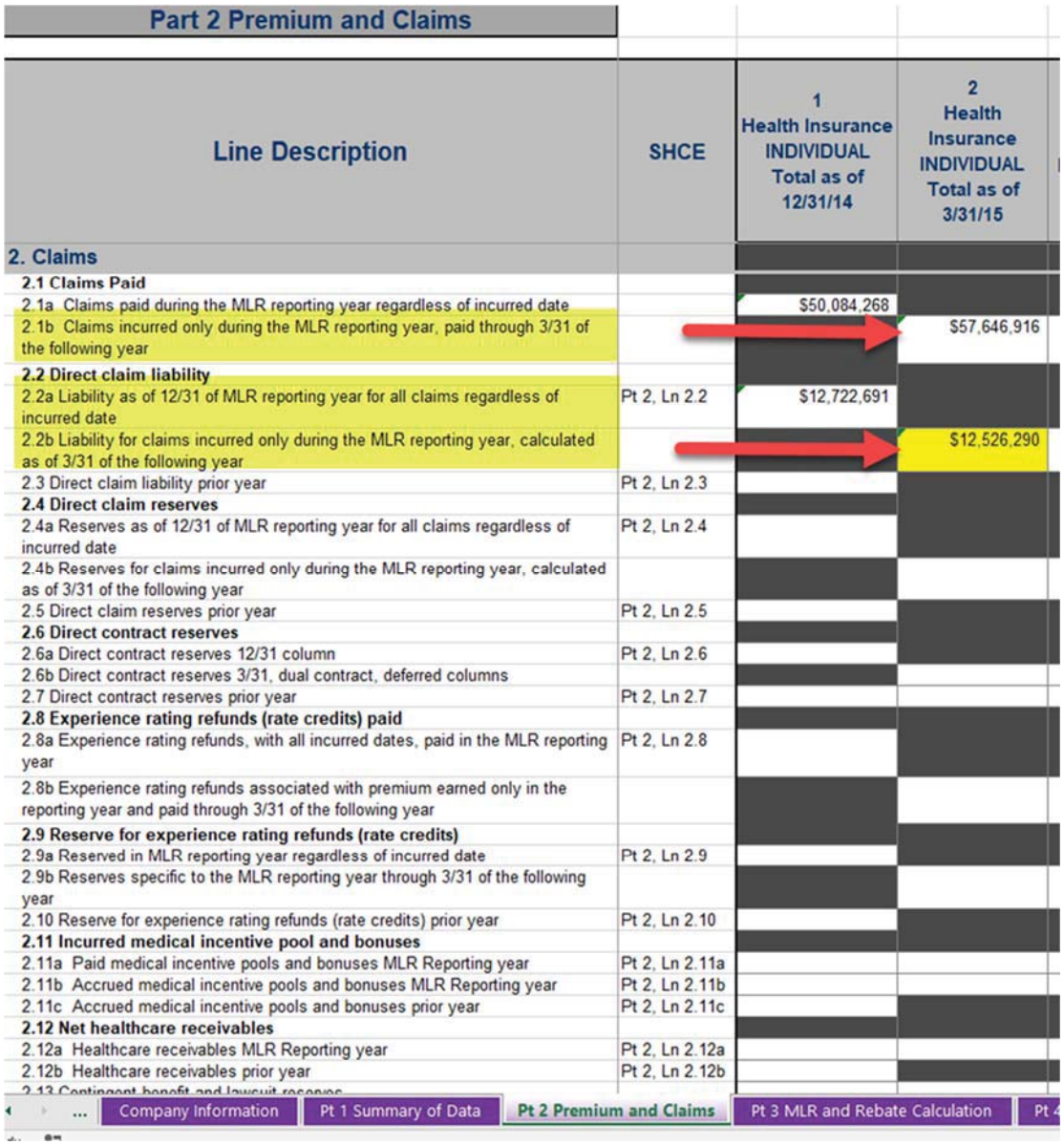
Figure 13
Fish Workpaper – Claims Lag 2014

										2014 Incurreds Received after 12/31/14			5,696,595
										2014 Incurreds Received after 4/30/15			654,984
										2014 Incurreds Received after 6/30/15			479,113
2014 Medical and RX Claims Received										2014 Incurreds Received after 5/31/15			394,665
Year	Month	Date Incurred											
Received	Received	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2014	JAN	322,647												322,647
2014	FEB	544,188	683,542											1,227,730
2014	MAR	119,043	731,368	1,165,124										2,015,535
2014	APR	58,177	300,531	875,621	1,768,123									3,002,453
2014	MAY	35,119	73,700	120,476	1,342,858	2,067,368			0	0				3,639,521
2014	JUN	119,766	42,859	130,623	301,197	1,769,219	2,522,068							4,885,732
2014	JUL	36,615	105,239	91,950	372,348	278,019	2,095,755	2,557,719	0					5,537,644
2014	AUG	95,233	67,894	136,297	118,077	151,303	266,402	1,642,597	2,946,007					5,423,810
2014	SEP	15,547	90,625	43,205	87,542	382,932	127,613	621,506	1,529,764	2,927,079				5,825,814
2014	OCT	21,478	57,119	28,179	26,888	101,538	92,663	716,828	443,349	2,124,735	3,512,590			7,125,369
2014	NOV	4,476	28,144	19,885	68,200	50,489	36,623	64,884	99,879	298,956	1,693,349	2,719,985		5,084,870
2014	DEC	7,751	16,292	17,043	21,234	16,551	63,970	75,924	120,673	326,453	512,954	2,127,243	3,446,191	6,752,278
2015	JAN	51,638	10,887	10,333	(10,658)	19,614	18,581	41,368	103,875	70,253	537,181	341,388	2,112,525	3,306,985
2015	FEB	8,348	7,625	4,628	22,096	11,523	13,647	40,412	64,808	43,987	86,527	111,849	269,946	685,393
2015	MAR	973	261	17,757	24,574	42,165	49,432	74,620	38,595	41,787	121,524	88,621	157,515	657,825
2015	APR	1,130	17,161	2,912	18,045	6,766	11,449	22,386	15,493	56,548	67,064	52,330	120,122	391,407
2015	MAY	993	3,966	3,714	5,477	7,879	5,635	13,371	19,712	24,645	12,200	55,497	107,232	260,319
2015	JUN	(57)	1,226	(3,063)	7,080	(4,431)	(62,980)	(3,091)	17,481	(31,503)	10,734	(34,621)	18,779	(84,448)
2015	JUL	1,599	(3,236)	(11,405)	(62,410)	(16,515)	(42,455)	16,085	28,823	(2,570)	38,163	10,987	23,330	(19,605)
2015	AUG	528	6,834	(220)	(494)	(63,861)	677	5,862	8,317	34,740	57,861	71,543	31,874	153,660
2015	SEP	0	8	(700)	31,130	6,703	8,189	10,591	53,864	26,989	35,472	55,089	35,374	262,709
2015	OCT	1,723		(194)	(188)	167	787	2,766	370	2,440	2,482	(10,013)	3,447	3,788
2015	NOV	104	(7,340)	(2,909)		464	700	(2,813)	(2,093)	(584)	(15,190)	(1,209)	9,568	(21,300)
2015	DEC	(154)	826			13,041	132	(1,999)	217	(19,460)	97	287	66	(6,947)
2016	JAN		0	0	0	0		306	1,627	348	(436)	9,791	(83)	11,553
2016	FEB	6		(793)	(2,579)	(94)	(100)	(520)		0	(166)		(1,258)	(5,505)
2016	MAR	(722)		(5,153)	(17,690)	0	39	295	(300)	(4,127)	(272)	301	(3,555)	(31,184)
2016	APR		0		0	275	546	361	14,055	9,787	11,287	1,147	1,405	38,862
2016	MAY		11			0	0	(312)	1,206	481	0	460	594	2,440
2016	JUN	1,224						1,880		857	(42)	1,921	0	5,841
2016	JUL	0		(104)		0	(192)		3	0	912	705	844	2,169
2016	AUG		0	185	540	855	0	1,986	716	45	(23,059)	6,717	6,544	(5,471)
2016	SEP	282		12	348	550	27	164	288	57,900	283	1,001	250	61,105
2016	OCT	514	666	1,954	580	226	2,267	90	461	675	4,011	4,576	2,612	18,631
2016	NOV				640		100	0	359	426	5,718	109	115	7,468
2016	DEC				(21)		60			4,546	(3,900)		213	897
		1,448,170	2,236,209	2,645,358	4,122,936	4,842,746	5,211,634	5,903,265	5,507,548	5,995,431	6,667,345	5,615,704	6,343,652	56,539,997

This analysis and the two referenced amounts are not consistent with the SDR's revised risk corridor calculations that Fish says are "reasonable."[380] A portion of the SDR's re-estimated risk corridor workbook[381] is below:

[378] 2015 Actual Premium and Membership Revenue. PLAINTIFF02499092.xlsx.
[379] PLANTIFF02499092.
[380] Fish Report II, p. 23. FN #64-65.
[381] The MLR Calculator with the 2014 MLR Annual Reporting Form. PLAINTIFF02479890.xlsm.

Figure 14
SDR's Re-Estimated Risk Corridor Workbook



Part 2 Premium and Claims

Line Description	SHCE	1 Health Insurance INDIVIDUAL Total as of 12/31/14	2 Health Insurance INDIVIDUAL Total as of 3/31/15
2. Claims			
2.1 Claims Paid			
2.1a Claims paid during the MLR reporting year regardless of incurred date		$50,084,268	
2.1b Claims incurred only during the MLR reporting year, paid through 3/31 of the following year			$57,646,916
2.2 Direct claim liability			
2.2a Liability as of 12/31 of MLR reporting year for all claims regardless of incurred date	Pt 2, Ln 2.2	$12,722,691	
2.2b Liability for claims incurred only during the MLR reporting year, calculated as of 3/31 of the following year			$12,526,290
2.3 Direct claim liability prior year	Pt 2, Ln 2.3		
2.4 Direct claim reserves			
2.4a Reserves as of 12/31 of MLR reporting year for all claims regardless of incurred date	Pt 2, Ln 2.4		
2.4b Reserves for claims incurred only during the MLR reporting year, calculated as of 3/31 of the following year			
2.5 Direct claim reserves prior year	Pt 2, Ln 2.5		
2.6 Direct contract reserves			
2.6a Direct contract reserves 12/31 column	Pt 2, Ln 2.6		
2.6b Direct contract reserves 3/31, dual contract, deferred columns			
2.7 Direct contract reserves prior year	Pt 2, Ln 2.7		
2.8 Experience rating refunds (rate credits) paid			
2.8a Experience rating refunds, with all incurred dates, paid in the MLR reporting year	Pt 2, Ln 2.8		
2.8b Experience rating refunds associated with premium earned only in the reporting year and paid through 3/31 of the following year			
2.9 Reserve for experience rating refunds (rate credits)			
2.9a Reserved in MLR reporting year regardless of incurred date	Pt 2, Ln 2.9		
2.9b Reserves specific to the MLR reporting year through 3/31 of the following year			
2.10 Reserve for experience rating refunds (rate credits) prior year	Pt 2, Ln 2.10		
2.11 Incurred medical incentive pool and bonuses			
2.11a Paid medical incentive pools and bonuses MLR Reporting year	Pt 2, Ln 2.11a		
2.11b Accrued medical incentive pools and bonuses MLR Reporting year	Pt 2, Ln 2.11b		
2.11c Accrued medical incentive pools and bonuses prior year	Pt 2, Ln 2.11c		
2.12 Net healthcare receivables			
2.12a Healthcare receivables MLR Reporting year	Pt 2, Ln 2.12a		
2.12b Healthcare receivables prior year	Pt 2, Ln 2.12b		
2.13 Contingent benefit and lawsuit reserves			

Company Information | Pt 1 Summary of Data | Pt 2 Premium and Claims | Pt 3 MLR and Rebate Calculation | Pt 4

The SDR's revised risk corridor workbook indicates that a total of $57.646 million was paid for 2014 incurred claims by March 31, 2015, while Fish's total incurred claims in 2014 and received from 2014-2016 is $56.539 million, a $1.1 million discrepancy. One would expect Fish's total to be larger than the SDR's given that the SDR's calculation contains only claims received from January 2014 to March 2015, whereas Fish's number contains claims received from January 2014 to December 2016.

In addition, the SDR's revised risk corridor workbook indicates $12.526 million for claims incurred in 2014 but not yet paid as of March 31, 2015, while Fish's working papers indicate a total of $5.697 million of claims incurred in 2014 and received after December 31, 2014, a discrepancy of over $6.83 million.

Both the SDR and Fish make no effort to reconcile these large discrepancies, nor do they discuss how their calculations can be "reasonable." I note that these discrepancies are approximately the amount of alleged damages identified in the DRAFT SDR Report and Fish's Report as shown in Fish's Table 7.

9.6 Uncollected Premiums from the Nevada State Exchange

The SDR states that UHH "under collected" premium payments from the Nevada State Exchange[382] although it was never UHH's responsibility to collect premium payments from members or from the State Exchange. In fact, "Barbara D. Richardson, Commissioner of Insurance in the State of Nevada, in her official capacity as Permanent Receiver of Nevada Health Co-Op" is suing the Silver State Health Insurance Exchange, the party responsible for collection of premium payments.[383] In the Complaint against the Silver State Health Insurance Exchange, the Commissioner asserts that "Nevada citizens who purchased a health care insurance plan from [NHC] through the Exchange submitted their premium payments directly to [the Silver State Health Exchange] through the Exchange; and that "after collecting the premium payments" the Silver State Health Insurance Exchange "would transfer those premium payments to [NHC]".[384] The Commissioner further asserts that there was a contract between NHC and the Silver State Insurance Exchange that was breached when the Silver State Insurance Exchange failed to remit premium payments it collected to NHC for NHC plans purchased on the Exchange.[385]Contrary to the allegations in the Commissioner's Complaint, the experts hired by the SDR in this matter are asserting that collection of premiums was UHH's responsibility, with which the Commissioner (the Receiver herein) clearly disagrees. In the Second Demand for Payment of Underpaid Premium Amounts to NHC, the Commissioner/Receiver's position is clear that "NHC relied solely on the Exchange for 2014 premium data."[386]

[382] DRAFT SDR Report, p. 21 & 22. PLAINTIFF02479813-02479851 at 02479833-34. Fish Report II, p.32, ¶6.
[383] Complaint. State of Nevada, Ex. Rel. Commissioner of Insurance, Barbara D. Richardson v. Silver State Health Insurance (June 5, 2020). Case No: A-20-816161- C.
[384] Complaint. State of Nevada, Ex. Rel. Commissioner of Insurance, Barbara D. Richardson v. Silver State Health Insurance (June 5, 2020). Case No: A-20-816161- C.
[385] Complaint. State of Nevada, Ex. Rel. Commissioner of Insurance, Barbara D. Richardson v. Silver State Health Insurance (June 5, 2020). Case No: A-20-816161- C.
[386] Letter from Mark Bennett, Special Deputy Receiver of Nevada Health CO-OP, to Heather Korbulic, Executive Director of Silver State Health Insurance Exchange, Regarding Nevada Health CO-OP ("NHC"); Second Demand for Payment of Underpaid Premium Amounts to NHC: Your File No. 70750-000, dated September 6, 2019. PLAINTIFF02499214-02499215.

nevada health co-op
In Receivership for Liquidation

BARBARA D. RICHARDSON, *Receiver*
CANTILO & BENNETT, L.L.P., *Special Deputy Receiver*

September 6, 2019

VIA E-MAIL (hkorbulic@exchange.nv.gov)

Ms. Heather Korbulic
Executive Director
Silver State Health Insurance Exchange

Re: Nevada Health CO-OP ("NHC"); Second Demand for Payment of Underpaid Premium Amounts to NHC; Our File No. 70750-000

Dear Ms. Korbulic:

This letter is in response to your letter dated April 17, 2019, regarding NHC's request for payment relating to an underpayment of 2014 premiums, and there has been a delay in responding while we addressed some other receivership matters. We had previously requested all premium payment information pertaining to NHC, and the data that the Exchange provided included columns that showed a "coverage total" that exceeds the "check amount" total by $510,651.27.[1] Before our initial demand letter, we requested further information for these columns, or any reasonable explanation aside from the appearance of an underpayment—and the Exchange did not provide further information concerning its own data. As such, $510,651.27 is owed to NHC by the Exchange.

To recap, our request for payment is based upon data that we received directly from the Exchange—the spreadsheet that we provided with our prior letter comes directly from a table that was transferred to us from the Exchange. NHC relied solely on the Exchange for 2014 premium data, as the Exchange was the intermediary that collected premium monies (and NHC did not collect these premium monies directly). NHC does not have a source for premium data outside of the data received from the Exchange, and in response to your reply letter, there is therefore no reason that NHC should provide data to the Exchange—as the Exchange itself (and not NHC) is the source for the data that reflects a balance now due NHC.

From your letter, we understand that the Exchange is concerned about the quality of Xerox data.[2] However, the Exchange (not NHC) is responsible for shortcomings, if any, in the quality of the work of its vendor, Xerox. The Exchange has provided no legal basis for its apparent position that NHC should bear the damages of failures by the Exchange or its vendor, Xerox (with whom NHC has no direct contractual relation).

It should be noted that Osowski simply accepts the SDR's allegation in this case and inappropriately assigns causation for uncollected premiums to UHH: "UHH is responsible for under collected premium payments from the HIE totaling $510,651.27 in 2014 by not setting up proper data systems to maintain and track NHC enrollment files, including no setup of a proper data system for the reconciliation of membership enrollment with the HIE."[387]

The determination of member eligibility was clearly a responsibility of NHC, as is established in the ASA.[388] The SDR acknowledges that it was NHC and the State Exchange's responsibility to handle enrollment, payment processing, and reconciliation, *not* UHH. Specifically, the SDR correctly asserts that

[387] Osowski Report II, p. 73.
[388] ASA, Exhibit A, ¶5.

the State Exchange "handled enrollment and payment processing functions for NHC, providing the resulting information and premium payments on a monthly basis to the CO-OP as part of a records reconciliation process."[389] However, the SDR then goes on to suggest, without any foundation or evidence, that UHH, in its role as TPA, was to override NHC's determination of member eligibility (i.e., due to lack of premium payment), something that UHH had no authority to do.

NHC performed member eligibility determinations and reconciliations with the State Exchange premium payment data. This is clearly demonstrated in the email exchange on July 23, 2014, regarding "Member Premiums added to detail file for Xerox Rec" among Gary Odenweller, Ryan Myers (Sr. Financial Analyst), Basil Dibsie (CFO), Gwendolyn Harris (Compliance Officer) and Lisa Simons (Enrollment Manager), *all* NHC staff, which discussed the reconciliation of premium payments from the State Exchange with eligibility information in Javelina.[390] The email states:

From: Odenweller, Gary [mailto:GODENWELLER@uniteherehealth.org]
Sent: Wednesday, July 23, 2014 4:08 PM
To: Ryan Myers
Cc: Basil Dibsie; Gwendolyn Harris; Lisa Simons
Subject: RE: Member Premiums added to detail file for Xerox Rec

Ryan,
Per our phone conversation, and following an extensive conversation I had with Lisa Simons, I'm sorry to say that the premium information that you are seeking is just not available.

In my discussion with Lisa, I advised her that I was unable to reconcile either the Billing History files or the Payment files to the membership population information. There were thousands of members for whom I could not locate any premium billing or payment information. Lisa told me that was because there were many erroneous records provided by the Exchange, and those records had not been entered into Javelina for several months for fear the many errors would contaminate the valid records already existing in Javelina. She indicated that she and her staff work on identifying and correcting the problems as time permits, but other priorities have caused delays in fixing the incorrect information supplied by the Exchange.

In the absence of complete and accurate premium/payment data, I'm unable to provide you with a meaningful report for your reconciliation. Let me know if you have any questions or need any further information.

-Gary

Gary M. Odenweller
10078 Hidden Pines Lane, Bonita Springs, FL 34135
Cell: (630) 452-5505 Ph: (239) 301-0979
godenweller@nevadahealthcoop.org

This NHC email shows that UHH staff were not even part of the discussions regarding the reconciliation between State Exchange premium payments, enrollment, eligibility, and Javelina, as this was a NHC responsibility and is reflected in the contemporaneous email correspondence. This reality is in stark

[389] DRAFT SDR Report, p. 21. PLAINTIFF02479813-02479851 at 02479833.
[390] Email between Ryan Myers, Sr. Financial Analyst/Underwriter of NHC, and Gary M. Odenweller, NHC, Regarding Member Premiums added to detail file for Xerox Rec, dated July 23, 2014. PLAINTIFF00043890-00043891 at PLAINTIFF00043890.

contrast to the ex-post rewriting of history attempted by the SDR where UHH was (incorrectly) alleged to have been responsible for determinations of member eligibility and premium payments.

This email further highlights the failure of the State Exchange (and Xerox) to provide actionable data and information to NHC on enrollment and premium payments, so much so, that NHC's enrollment team had not been entering the information into Javelina for *months* for fear the many errors would *contaminate* the valid eligibility records already in Javelina. Lastly, this correspondence demonstrates that it was Lisa Simons' (NHC's Enrollment Manager) team that was in charge of identifying and correcting the problems associated with the enrollment and premium data from the State Exchange (and Xerox), not UHH. Yet the SDR attributes alleged damages to UHH for the failures of NHC and the State Exchange, and for roles and responsibilities that UHH was not authorized to perform.

Not only does the SDR fail to demonstrate how there are premium payment damages attributable to UHH, the SDR's demand letter for payment of underpaid premiums to the State Exchange, dated March 29, 2019, raises questions as to whether underpayments actually occurred. Specifically, the SDR demand letter characterizes the $510,651.27 alleged underpayment as an "apparent" underpayment and requests that the State Exchange help investigate the premiums with "insights" and "explanations",[391] even though in the last sentence of the letter the SDR ultimately demands the funds directly from the State Exchange. Like so many of the SDR's demands, this letter and analysis raise the question as to why UHH is even involved in these damage allegations, which are for alleged mistakes and errors surrounding NHC's activities and involving the reconciliations of data sets for which UHH, as TPA, was not responsible.

9.7 Fish's Estimates an Expected Dollar Range of Denials Based Upon a Single Source and Fails to use the Single Source's Finding Correctly, Rendering his Expected Denial Amounts Deficient and therefore Unreliable.

Fish (inappropriately) uses the findings from a single source[392] to justify his alternative claims denial rate of 5 percent to 10 percent and Table 10's damage range of $770,000 to $1,540,000 with respect to NHS.[393] Specifically, Fish cites a 15-year-old research brief from the RAND Corporation as the sole basis for his denial rate estimates. This 15-year-old RAND Corporation brief, however, does not support Mr. Fish's use of its denial rates. The RAND Corporation researchers expressly made it clear that their results cannot be generalized:

[391] PLAINTIFF02479935.
[392] RAND Institute for Civil Justice RAND Health. "Inside the black box of managed care decisions: Understanding patient disputes over coverage denials". Research Brief, dated 2004. Available at https://www.rand.org/pubs/research_briefs/RB9039.html.
[393] Fish report II, p.35.

> "These studies are based on data from two HMOs and two medical groups in California. Therefore, they cannot be generalized to the country as a whole."[394]

Fish also neglects to identify other significant limitations of the research brief, mainly that the denial rate of 9 percent is calculated before any patients appeal their denials. In other words, the estimated dollar range of denials presented in Fish's Table 9 do not include the results of patient appeals. Therefore, these estimated dollar amounts do not represent damages because they exclude the amounts patients would ultimately be paid after their appeal processes have been completed. The research Fish, himself, cites identifies the success rates of appeals, indicating that:

> "Enrollees won more than three-fourths of all post-services appeals…"[395]
> "Patients won nearly all appeals over emergency care." [396]
> "The most striking finding: Patients prevailed in over 90 percent of appeals involving emergency department care."[397]

If Fish applied the 90 percent successful prevailing appeals rate to his cited 9 percent denial rate, the post-appeal denial rate would be less than 1 percent, much closer to the "very small number of claims" that were denied by NHC.

The RAND Corporation research brief also describes how the denial rate varies significantly across the different types of procedures and claims. For example, the most commonly denied claims involved durable medical equipment. Denial rates for durable medical equipment were 23 percent versus relatively low denial rates for speech therapy and chiropractic services. Fish does nothing to differentiate denial rates by the types of claims and inappropriately applies a single aggregate denial rate across a spectrum of claims, counter to the very research brief he cites.

9.8 Avoidable Costs of Additional Losses

Fish fails to establish any link between the alleged claims backlog[398] and NHC's failure to (i) accurately record IBNR, (ii) calculate the PDR for year 2014, and (iii) file accurate financial statements. Fish and

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[394] RAND Institute for Civil Justice RAND Health. "Inside the black box of managed care decisions: Understanding patient disputes over coverage denials". Research Brief, dated 2004, p4. Available at https://www.rand.org/pubs/research_briefs/RB9039.html.
[395] RAND Institute for Civil Justice RAND Health. "Inside the black box of managed care decisions: Understanding patient disputes over coverage denials". Research Brief, dated 2004, p. 2. Available at https://www.rand.org/pubs/research_briefs/RB9039.html.
[396] RAND Institute for Civil Justice RAND Health. "Inside the black box of managed care decisions: Understanding patient disputes over coverage denials". Research Brief, dated 2004, p. 2. Available at https://www.rand.org/pubs/research_briefs/RB9039.html.
[397] RAND Institute for Civil Justice RAND Health. "Inside the black box of managed care decisions: Understanding patient disputes over coverage denials". Research Brief, dated 2004, p. 3. Available at https://www.rand.org/pubs/research_briefs/RB9039.html.
[398] Fish Report II, pp. 25-26, Charts 1-4.

DeVito opine multiple times that Milliman, Larson, and NHC management were responsible for these failures, including but not limited to:

- "..based upon my review of the information available at the time NHC was developing its year-end 2014 financial statements, NHC's financial statements as of December 31, 2014 did not accurately reflect the company's true financial position. Specifically, NHC understated IBNR and chose not to recognize a PDR despite the negative 2014 financial results."[399]
- Furthermore, Larson and Company, its auditors failed to disclose these inadequacies in their various reports relied on by the NDOI. Had NHC accurately recorded the IBNR reserve and recognized a PDR in their annual filing to the NDOI, the resulting impact to statutory surplus and RBC would have triggered regulatory action. The impact of appropriate IBNR and PDR reserve levels on year-end 2014 statutory surplus."[400]
- Noting the unprocessed claims for calendar year 2014, Fish was able to calculate "IBNR using paid claims data available as of February-2015."[401]
- Fish states, "To assess the appropriateness of a $0 PDR for year-end 2014, I analyzed NHC data that was available at February 2015, data which could have been used at the time to determine if a PDR was required as part of NHC's annual statement filing."[402]
- "Consequently, NHC's 2014 results, related assumptions, and NHC's overall operational performance indicators, such as NHC's ability to pay claims timely and accurately, should have been critical factors in forming Milliman's opinion. In my opinion, however, Milliman, in conjunction with NHC management, chose overly aggressive assumptions that did not reflect NHC's actual experience."[403]
- "Further, as previously mentioned, Milliman and NHC management should have accounted for the substantial backlog of unprocessed claims when Milliman developed the initial 2014 year-end IBNR reserve on March 1, 2015, which Milliman then increased by $5 million in the revised May 14, 2015, opinion, approximately only two months later."[404]
- "Milliman and NHC management also made the unrealistic assumption that the IBNR increase reflected in Milliman's May 14, 2015, opinion would mostly be offset by an increase in the federal Risk Corridors receivable, with both adjustments reflected in Larson's year-end audit. However, it should have been apparent that NHC would not fully recover the federal receivables, including Risk Corridors, since given the substantial claims backlog, NHC would not be able to process the 2014 claims timely before the submission deadline used to determine the 2014 federal receivables."[405]

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[399] Fish Report II, p.7.
[400] Fish Report II, p.7.
[401] Fish Report II, p. 13. See also "Ms. Silver asked about the claims lag data and how it impacted Milliman estimates. Mr. Dibsie explained current data was used including all pended and paid claims data from the system." NHC Meeting Minutes August 26, 2014. LARSON014403-014409 at 014403.
[402] Fish Report II, p. 14.
[403] Fish Report II, p. 16.
[404] Fish Report II, p.17.
[405] Fish Report II, p. 17.

- "Larson issued audit opinions that failed to comply with SAP, as prescribed or permitted by the Nevada DOI in the conduct of its audits of NHC, for the years ended December 31, 2013 and December 31, 2014. For the year ended December 31, 2014, Larson failed to adequately audit and evaluate Premium Deficiency Reserves ("PDR"), Claim Reserves and Incurred But Not Reported ("IBNR") claims, significant receivables and failed to adequately audit and disclose the existence of substantial doubt about NHC's ability to continue as a going concern and, as a result, increased the losses ultimately suffered by NHC."[406]
- "Larson should have recognized by March 31, 2015 that NHC had materially misstated its year-end 2014 financial condition and its ability to meet minimum capital and surplus requirements at year-end 2014."[407]
- "NHC's financial condition would make the company subject to being placed into receivership as of March 31, 2015, if NHC or Larson had reported to the Nevada Commissioner NHC's misstated 2014 financial condition and its inability to meet minimum capital and surplus requirements at year-end 2014 only; or, if Larson had reported to the Nevada Commissioner that NHC's internal controls were inadequate to prevent a material misstatement of NHC's financial statements."[408]
- "Larson's 2014 audit workpapers contain no audit evidence indicating that an evaluation of NHC's ability to continue as a going concern was conducted."[409]
- "Per FTI's Expert Report, Mr. Mark Fish used data that was available in February 2015 and could also have been used by Larson during the conduct of its 2014 audit to determine whether a PDR was required as of December 31, 2014."[410]
- "Per FTI's Expert Report, Mr. Mark Fish used the data of subsequent operational results that was available to Larson prior to the issuance of its audit report to determine whether a PDR was required as of December 31, 2014."[411]
- "In particular, had Larson properly audited NHC's internal controls over the completeness and accuracy of its claims processing and payments systems, Larson should have found the existence of a significant claims backlog, should have reported this material internal control weakness to NHC's Board of Directors and/or Audit Committee, should have developed audit procedures to adequately audit Milliman's initial calculation of IBNR giving consideration to obtaining an independent actuary, and ultimately would have known, on or about March 31, 2015, that IBNR was understated by approximately $5.0 million."[412]
- "By not requiring NHC to at least record these three adjustments as of December 31, 2014, Larson enabled NHC to continue its operations while insolvent, causing additional losses and NHC's total deficit to grow."[413] (adjustments: "PDR of approximately $15.8 million… as the best

[406] DeVito Report, pp. 2-3.
[407] DeVito Report, p. 3.
[408] DeVito Report, p. 3.
[409] DeVito Report, p. 20.
[410] DeVito Report, p. 25.
[411] DeVito Report, p. 26.
[412] DeVito Report, p. 28.
[413] DeVito Report, p. 39.

- estimate made by Mr. Mark Fish," "improper recognition of the $3.1 million Solvency Loan," and "the understatement of claim adjusting costs of approximately $826,000."[414])
- "As detailed above, Larson should have recognized no later than March 31, 2015 that NHC's 2014 Annual Statement filed with the Nevada DOI and the NAIC was materially misstated and that NHC did not meet minimum capital and surplus requirements."[415]

Importantly Fish opines that:

> "In my opinion, had NHC accurately recorded the IBNR reserve, recognized a PDR, and booked the Catamaran payable in their NAIC annual statement filing to the Nevada DOI, the resulting impact to statutory surplus and RBC would have triggered regulatory action. Consequently, NHC would have recognized its insolvency sooner, forcing the wind-down and closure of insurance operations sooner, and avoiding additional losses incurred throughout 2015."[416]

and

> "Based on my review, Larson did not perform appropriate checks on Milliman's work or follow through on the concerns of regulators of which Larson was aware. These failures allowed continued operations and continued losses through 2015."[417]

Although Fish states, "the delays in claims processing and associated claims backlog had severe operational and financial impacts on NHC"[418] and "Furthermore, NHC's inability to timely process and report its accurate claims liability for 2014 was a key factor to its later inaccurate reporting of financials for that year, which also enabled the company to stay in business in 2015 longer than it should have,"[419] these statements contradict his earlier opinions that (i) NHC, Milliman, and Larson had the requisite information available at the time NHC was developing its year-end 2014 financial statements, (ii) the claims backlog should have been accounted for, and (iii) his calculations use data available as of February-2015. Although clearly unreliable, neither of Fish's contradictory opinions support his overall conclusory opinion that UHH caused Plaintiff's alleged damages for avoidable costs.

10. Conclusion

In my opinion, neither UHH nor NHS (either individually or collectively) caused, nor were they a substantial factor in bringing about NHC's failure/insolvency. The entire Federal CO-OP program failed. NHC failed for the same reasons that nearly all of the federally funded CO-OPs failed, i.e., they experienced unexpectedly high claims costs and they did not receive the financial assistance they were promised by the Federal government. Contrary to Osowski's opinion, it is my opinion that UHH and NHS

[414] DeVito Report, p. 38.
[415] DeVito Report, p. 41.
[416] Fish Report II, p.18.
[417] Fish Report II, p.19.
[418] Fish Report II, p. 27.
[419] Fish Report II, p.19.

performed effectively and that NHC would have failed or otherwise become insolvent regardless of the actions or inactions of UHH and/or NHS. Further, the alleged damages cited by the SDR, Fish, and Osowski are methodologically flawed; their damage calculations are deficient and therefore unreliable. Most importantly, in my opinion, NHC would have failed even if UHH and NHS had performed their functions perfectly.

This report is based on information known to me as of this date. If additional information is made available, I may modify my report. I may also be asked to present opinions on additional issues in this case.

Henry Miller, Ph.D. October 2, 2020

EXHIBIT 8

EXHIBIT 8

RTRAN

DISTRICT COURT

CLARK COUNTY, NEVADA

STATE OF NEVADA, EX REL COMMISSIONER OF INSURANCE, Plaintiff, vs. NEVADA HEALTH CO-OP, Defendant.	CASE NO. A-15-725244-C DEPT. NO. 1

BEFORE THE HONORABLE KENNETH C. CORY, DISTRICT JUDGE

TUESDAY, JANUARY 10, 2017 AT 9:41 A.M.

RECORDER'S TRANSCRIPT RE:
DEFENDANT'S MOTION TO APPROVE PROFESSIONAL FEE RATES ON AN ORDER SHORTENING TIME

APPEARANCES:

FOR THE PLAINTIFF: JOANNA N. GRIGORIEV
(Senior Deputy Attorney General)
JAMES E. WHITMIRE, III, ESQ.
MARK E. FERRARIO, ESQ.

ALSO PRESENT: MARK BENNETT
Special Deputy Receiver

Recorded by: LISA A. LIZOTTE, COURT RECORDER

(TUESDAY, JANUARY 10, 2017 AT 9:41 A.M.)

THE CLERK: Page 10, State of Nevada versus Nevada Health CO-OP, Case Number A725244.

MS. GRIGORIEV: Good morning, Your Honor.

THE COURT: Good morning.

MS. GRIGORIEV: Joanna Grigoriev for the Commissioner of Insurance.

MR. BENNETT: Mark Bennett as the authorized representative for the Special Deputy Receiver.

THE COURT: Good morning.

MR. WHITMIRE: Good morning, Your Honor. Jim Whitmire also appearing on behalf of the Commissioner.

MR. FERRARIO: Mark Ferrario, Your Honor, on behalf of the Commissioner as well.

THE COURT: Good morning. Thank you all for coming. I put this back on, I think – this was going to be in chambers originally, was it not?

MS. GRIGORIEV: No. This was a motion on the – we requested order shortening time and the Court scheduled it for – for today in open court. There was no other date. This – this is Receiver's motion to – to get the Court's approval of engagement of certain professionals under 696B.290, and two of the – two of the proposed parties to be retained are here.

THE COURT: I had no problem signing this, and I see that – I don't remember the exact verbiage, but it says the Court is supposed to do it or can't be -- unreasonably refused to or some such thing, but the thing – the only question I had was I don't know – I don't have a feel for how far is this going to

go. I mean these are – this is a whole phalanx of highly qualified and – I mean you even have, let's see, the top – the top one in the hourly department, I think, was Mr. Ferrario. They're highly qualified, and obviously they're going to cost money but I don't know where is that coming from, and I don't want to set up a situation where it just goes on ad infinitum and this tremendously important matter gets resolved basically by winding up with, gee, there's no monies left because we had to pay all these folks to try and administer it. Do you understand what I'm saying?

MS. GRIGORIEV: I understand, Your Honor, very well, and I think maybe Mr. Bennett, Special Deputy Receiver, can give a better overview of how he sees the case proceeding.

THE COURT: Thank you. Mr. Bennett?

MR. BENNETT: Yes, Your Honor. In the receivership estate we have currently about 10 million dollars of assets and we have in excess of 40 million dollars of claims, and that claim tally continues to rise. We have very substantial recoveries that we should be able to make from the Center of Medicaid and Medicare Services, but they are refusing to pay those amounts under different legal theories and –

THE COURT: A bunch of obfuscation or –

MR. BENNETT: Yes. A good part of it is, some of it are just difficult issues and so forth, but –

THE COURT: Do you – when you say that, you're talking about some of the federal involvement here, I assume.

MR. BENNETT: That is right. That is right.

THE COURT: Are we likely – I saw the notice, I think, on this very motion it went to look like everybody in Washington D.C. as well as Nevada -- I'm exaggerating – U.S. Department of Health and Human Services, U.S. Department of Justice, so are we going to wind up with contested hearings on this matter involving you folks against the government, the federal government?

MR. BENNETT: We – we may but we may not wind up with that in this court.

THE COURT: But that's a potential at least?

MR. BENNETT: Jurisdictional issues, yes.

THE COURT: Okay.

MR. BENNETT: We might wind up in federal court with the United States government or in the Court of Federal Claims in D.C., and one of the attributes of the Greenberg Traurig firm is that they have offices in the Washington D.C. area, so that's a help to us.

THE COURT: Let me – I want to hear more about what you're saying, but let me just as this question occurs to me pop it out there. It would be easy with this many parties, cumbersome parties to even deal with and counsel, not only local but now all over the place, to wind up spending untoward amounts of money in trying to litigate this stuff out rather than having anything for the claimants, and part of my concern is, and I guess part of my question is, is there anything I can do as a Judge, a little old State District Court Judge here, to try and get the issues themselves flushed out so that we don't get a bunch of -- whether you call it obfuscation or whether it's the federal government doing what it does best which is delay -- did I say that -- and we never really get down to the issues because it's just a staying action, it's just, you know, we never really get

down to the issues and resolve them so that whatever monies are available can go to those who need it the most?

MR. BENNETT: I understand, Your Honor. First, the Center of Medicaid and Medicare Services owes approximately 57 million to the receivership estate and they have some theories, and there's some recent appellate case law where the federal government may be able to diminish some of that amount but even if some of that amount is diminished there is still a very substantial amount that is owed by CMS.

The problem is that this is a very highly political issue in Congress where Republicans have been fighting with Democrats, and no one wants to let any money be squeezed out to pay any of these poor CO-OPS that are owed sizable amounts of money and so the United States Department of Justice has dug in and is not doing anything, and so I don't see where there would be something at least –

THE COURT: I'm sure Senator Sessions would be very quick to pay the money out as soon as he gets the job, don't you think? These are all jokes, by the way. There's nothing serious intended here.

MR. BENNETT: Well, I was going to say that maybe so, but knowing President Elect Trump they'd want to negotiate substantially – substantially down, but Your Honor –

THE COURT: Well, so I guess maybe you can tell where I'm kind of coming from. This – this is a matter that deserves the best of the professional help that can be assembled on behalf of these claimants, but my fear is that we've got 10 million now, there's 40 million so far in claimants and it's going to be on the rise and how much of that 10 million are we going to spend in what really

amounts to a losing cause not because of justice but because you can't – you can't get the ball across the goal line?

Is there any – is there any reason – this is – I know how you have to answer this, but is there any reason for this Court to just say, no, let's not spend the money on chasing those dollars and just spend the money on a more curtailed aspect of the claimants, the claims in paying off what can be paid? I don't think you even have to answer that question. That's –

MR. BENNETT: Well, I'm tracking what you're saying. We've spent a lot of time thinking about that, and if we were to just do the status quo and not engage outside counsel to try to pursue asset recovery actions -- and incidentally it's not just the federal government but there are other private entities and parties that we believe may have some culpability for the downfall of this company and that they should be held accountable for that, so there's more potential asset recovery litigation than just CMS which as I said is 57 million dollars, but if we don't pursue that track of trying to get those asset recoveries we know that we are probably going to pay maybe 5 to 10 cents on the dollar for these claims which is a very paltry amount. If we –

THE COURT: And that's even if we just stopped the drain now? In other words, that's even if the Court said, oh, no, don't hire all the expensive lawyers and consultants, just pay what you can, it's going to be –

MR. BENNETT: It could be – it could be that low. It could be that low. It might be a little higher but it could be that low, and then we could do – we have the possibility of doing a lot better if we engage counsel to pursue these actions and to try to bring money into the receivership estate.

THE COURT: Yeah. I don't know that, in any event, the Court even has the power to say, no, don't hire these people. It's really not for me to say, but I just have felt like this is such an important matter and a critical failing in our state that it's worth at least counting the cost before we set out to slay the giant leaving you, of course.

MR. BENNETT: Understood.

THE COURT: All right. I think you've satisfied me that I don't see any reason why I shouldn't just grant your request.

MS. GRIGORIEV: Your Honor, I will prepare the order. Just one – one other matter that I wanted to bring up. In February the Court granted the Receiver's motion to allow certain hardship payments, it was the February 25th order, and the Receiver just wanted to clarify that from time to time these payments will still be made with the Court approval.

THE COURT: Remind me, if you would, who the hardship payment went to.

MS. GRIGORIEV: Some hardship payments have to be made to providers or members depending on the circumstances, and in February the Receiver had submitted a motion describing – these are sporadic payments on a case-by-case basis.

THE COURT: Are these to claimants or are these to –

MS. GRIGORIEV: These are to potential claimants and now with the liquidation in process to claimants, so we just wanted to clarify that these will continue from time to time.

THE COURT: And inasmuch as the Court's not going to hold up – I mean you've asked for the Court to not require you to come in and ask the

Court's permission to make payments each time but rather to make the payments and then in the regular filings or the quarterly?

MS. GRIGORIEV: Reports, yeah. Submit the – the statute requires the Court's approval of the engagement of certain parties and the one time rate approval, thereafter the Receiver pays and submits the invoices and summary reports quarterly.

THE COURT: All right. I understand what you're saying.

MS. GRIGORIEV: Thank you, Your Honor.

MR. WHITMIRE: Your Honor, one other housekeeping item. In terms of submitting invoices and backup to the Court, anecdotally Mr. Bennett and I have worked on another matter in front of Judge Gonzalez, and what we did was submitted all of the backup for the attorney fee bills in camera so that we didn't have, you know, other parties seeing work product and privileged information. We wanted to make sure that we had the blessing of the Court concerning that issue.

THE COURT: I think that's a reasonable approach.

MR. WHITMIRE: And then the second issue anecdotally for what it's worth in response to Your Honor's questions to Mr. Bennett a few moments ago, the receivership case that we've been litigating since, I guess, 2013 involving NCIC, Nevada Contractors Insurance Company and Builders Insurance Company, the fuel tank was very minimally full in terms of assets. We pursued asset recoveries. Unquestionably it costs money to make money, but I think at the end of the day the money was well invested in terms of the return on investment.

Obviously there's no reps and warranties, what have you, in connection with this case of what will ultimately happen, but the Court's questions certainly are – we're cognizant of the issues, and, you know, who knows what will happen but hopefully it will be – it will bear fruit.

THE COURT: Am I correct that for these claimants who submit claims and ultimately they don't – it doesn't get paid at least on a hundred percent, whether it's 10 cents on the dollar or it's 75 cents on the dollar, that those claimants then are going to have to pay the medical services out of their pocket – pay their share of the medical services out of their pocket?

MR. BENNETT: That will happen in some circumstances, Your Honor, where there is not a Hold Harmless Agreement that the CO-OP has with the provider to not bill the members. In other circumstances there is no Hold Harmless, so there will be some direct billing from members, and then, of course, there will be those situations where members just owe the money because it was over the reimbursable amount that the CO-OP would pay.

THE COURT: Okay. All right. Thank you.

MR. BENNETT: Your Honor, if I may also clarify one thing about the in camera submission. Mr. Whitmire mentioned about attorney bills. We would also like to submit the detailed billing of the experts in camera as well so that we don't –

THE COURT: Very good.

MR. BENNETT: -- reveal expert detail.

THE COURT: What do I need as a basis under our statute in order to do this? I assume you have that all worked out from before when you did this with Judge Gonzalez.

MR. WHITMIRE: We do in terms of case cites or statutory authority. I do not have that –

THE COURT: Will you submit that when –

MR. WHITMIRE: Sure.

THE COURT: -- you know, at whatever point you begin doing this there better be – have been the Court looking to see that it satisfies the statute. I have no doubt it will but that's what needs to take place.

MR. BENNETT: Your Honor, if we may since the next time we're going to submit those bills would be with the next status report, we could include those case cites with the next status report.

THE COURT: Great. That would be great. Mr. Ferrario?

MR. FERRARIO: Your Honor, I think your points are well taken. I just wanted to tell you that the lawyers that are being retained and the lawyers that have already been on this are keenly aware of the balance that needs to be struck, so no one is looking at this –

THE COURT: Are you guys ready to go out and slay the giant?

MR. FERRARIO: Well, we're –

MR. BENNETT: They promised.

MR. FERRARIO: You raised some good points. They're fascinating issues that have arisen because this is a – as Your Honor knows, it's a unique situation. There's no shortage of ground that's already been plowed around the country, so there's a lot of work product that we can – we can benefit from, but we're all aware of the balance in these constructs.

THE COURT: How many other states are in the same boat? I mean do you recall?

MR. BENNETT: Just about everyone is.

MR. FERRARIO: Yeah.

MR. BENNETT: There's twenty something other CO-OPS that are in the same boat.

THE COURT: Okay. Thank you.

MR. FERRARIO: Thank you, Your Honor.

MR. BENNETT: Thank you.

MS. GRIGORIEV: Thank you, Your Honor.

THE COURT: Thank you.

(Whereupon, the proceedings concluded.)

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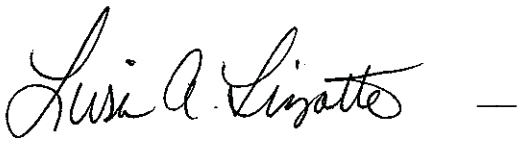
ATTEST: I do hereby certify that I have truly and correctly transcribed the audio/visual proceedings in the above-entitled case to the best of my ability.



LISA A. LIZOTTE
Court Recorder